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THESIS

TRI-SERVICES COORDINATED CARE (TRICARE)
A STUDY OF CHANGE
MANAGEMENT

by

Mari K. Dyson

December, 1993

Thesis Advisors:

Gail Thomas
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Tri-Services Coordinated Care (TRICARE)

A Study of Change

Management

by

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Lieutenant, United States Navy

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Submitted in partial fulfillment

of the requirements for the degree of

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This thesis is a case study of the Tri-Service Coordinated Care (TRICARE) Program in the Tidewater area of Virginia. TRICARE was established as a direct result of a memorandum published by Mr. Enrique Mendez, Assistant Secretary of Defense (Health Affairs) titled "Strengthening the Medical Functions of the Department of Defense." This paper begins with a brief history of medical care in the United States and the United States Navy. It continues with a discussion of the trend in the Department of Defense toward more joint operations, not only in the completion of its military mission, but also that of its medical mission. This thesis analyzes the organizational changes required for implementation of the Coordinated Care Program and TRICARE's use of inter-service working groups to reduce the negative effects and difficulties associated with change in the organization.

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LIST OF ACRONYMS

AFB	AIR FORCE BASE
ASD (HA)	ASSISTANT SECRETARY OF DEFENSE for HEALTH AFFAIRS
BPA	BLANKET PURCHASE AGREEMENT
BUMED	BUREAU OF MEDICINE AND SURGERY
CBO	CONGRESSIONAL BUDGET OFFICE
CCP	COORDINATED CARE PROGRAM
CHAMPUS	CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
CHCS	COMPOSITE HEALTH CARE SYSTEM
CINCLANTFLT	COMMANDER IN CHIEF, U.S. ATLANTIC FLEET
DOD	DEPARTMENT OF DEFENSE
DV-HSS	DELAWARE VALLEY HEALTH SERVICES SYSTEM
HBA	HEALTH BENEFITS ADVISOR
HMO	HEALTH MAINTENANCE ORGANIZATION
JCS	JOINT CHIEF OF STAFF
MACD	MILITARY ACUTE CARE DEPARTMENT
MHSS	MILITARY HEALTH SERVICES SYSTEM
MTF	MEDICAL TREATMENT FACILITY
NAB	NAVAL AMPHIBIOUS BASE
NAS	NAVAL AIR STATION
NMC	NAVAL MEDICAL CENTER
OSD	OFFICE OF THE SECRETARY OF DEFENSE
PPO	PREFERRED PROVIDER ORGANIZATION
SFMC	SAN FRANCISCO MEDICAL COMMAND
RIT	RAPID IMPLEMENTATION TEAM
TRICARE	TRI-SERVICES COORDINATED CARE

I. INTRODUCTION¹

A. GENERAL DESCRIPTION

This thesis is an action research study concerning an ongoing organizational change of the Tri-Services Coordinated Care (TRICARE) program. The objectives of this thesis are to describe the Coordinated Care/Managed Care Program, explain the reasons that led the Department of Defense's medical community to implement this enormous organizational change, analyze why the military chose the Tidewater area as the site for this program, and, most importantly, to report the findings made during this field research.

B. RESEARCH

1. Data Collection.

Interviews were the primary means used to collect data on the Tidewater TRICARE Coordinated Care Program. The interview method of collecting data was chosen because it was determined to provide the best potential for gathering qualitative data. Personal interviews were conducted during a one week period in August 1993. Telephone interviews were

¹The first three chapters of this thesis were written in cooperation with Capt Guillermo Nerio, USMC and Capt Richard B. O'Connor, II, USA. Similarities between Chapters I, II and III of this thesis and theirs is intentional.

conducted between September and December 1993. Each telephone interview lasted between 30 and 45 minutes, and personal interviews lasted between one and two hours. Eight face-to-face interviews and sixteen telephone interviews were conducted (see Figure 1).

NUMBER OF INTERVIEWS BY LOCATION						
LOCATION	TRICARE PROJECT OFFICE	TRICARE SERVICE CTR	NMC PORTSMOUTH/ CLINICS	LANGLEY AFB	McDONALD ARMY HOSP	VA
NUMBER	8	2	4	4	3	3

FIGURE 1

Interviewees were selected from all over the Tidewater area including the three military hospitals, the VA hospital, subordinate clinics, TRICARE Service Centers, and the TRICARE Project Office.

The interviews were semi-structured which allowed the interviewer the freedom to pursue topics they deemed important. The interview protocol provided an introductory statement followed by general questions about the TRICARE program, how it affected the interviewee, and how well the program was operating. There was some degree of directiveness once the interview began. The interviewer asked probing descriptive questions (i.e., asking the interviewee to describe in depth what happened in a particular situation) and evaluative questions (i.e., asking the interviewee's opinion

regarding specific situations). The interview protocol was evaluated each evening during the interview week and was adjusted based on issue discoveries made by the interviewer. After determining what additional data was needed and where to obtain it, telephone interviews were used to obtain supplemental information. Telephone interviews were more directive in nature than the face-to-face interviews and focused on individual participation in the TRICARE program. Interviewees were asked direct, focused and specific questions. No formal or statistical method of sampling was used to select the interviewees. Interviews originated with managers at the TRICARE Project Office, and once a specific topic was formalized, subsequent telephone interviews were conducted with personnel from the hospitals and clinics. Several follow up interviews were also conducted with Project Office personnel. Each interview was tape-recorded while the interviewer took notes to ensure answers were recorded verbatim. Each interview was later transcribed by the interviewer and indexed both alphabetically and by location.

2. Data Analysis.

Data analysis was a continuous process. Data collected from the interviews was analyzed using qualitative methods. The first step in the analysis was to read each interview to determine the major issues identified by the interviewees. As the interviews were read, topic areas began

to develop and were immediately written down. Following the first reading, ideas were researched in the interview transcripts. This process allowed the generation of new ideas as well as permanently storing ideas for future analysis. Interviews were then reread for better clarity and understanding. Topic categories were then established, and the data was sorted into each category. The last step in the data analysis was to write, critique, and rewrite the text. This process was repeated until a finished product was achieved.

The field data was collected in the Tidewater area mainly through face-to-face and telephone interviews. Historical data on the TRICARE program was collected during interviews and from command archives. This data was studied using qualitative methods of analysis as well as organizational change management models.

C. BACKGROUND

The cost of health care in the military has been increasing beyond what can be covered within budget authorizations. In the last five years the military medical communities have sought to develop innovative ways to provide quality health care at a lower cost. On October 1, 1991, the Office of the Secretary of Defense (OSD) published a memorandum titled "Strengthening the Medical Functions of the Department of Defense." In this memorandum, the Secretary of Defense stated that "with increasingly tight constraints on

resources available for the national defense, the Department must aggressively pursue actions to execute its vital missions more effectively, including its medical mission." Also in this memorandum he directs the implementation of several organizational changes, one specifically being a Coordinated Care Program (CCP). As a result, the Department of Defense (DOD) initiated the Tri-Services Coordinated Care (TRICARE) program in the Tidewater area of Virginia.

D. RESEARCH QUESTIONS

There were no specific interview questions as this research began. This study was intended to be freely structured in order to remain receptive to current issues related to the TRICARE program. Thus, the broad questions taken to the field were:

1. What lead the military to change the way they provide health care and implement the Coordinated Care Program?
2. Why did the military medical community choose the Tidewater area as the site for the Coordinated Care Program?
3. What were the critical change issues that surfaced during the implementation of the TRICARE program?
4. What specific techniques were used to manage and facilitate the change from the traditional delivery of health care to the managed care/coordinated care system.

E. ORGANIZATION OF THE THESIS

Following the introduction chapter, this thesis is organized into five chapters. Chapter II discusses the history of health care in the public sector and culminates with the delivery of health care in the military, specifically the Navy. Chapter III contains information on the Department of Defense's shift towards joint operations in the military services, and how this has lead to successful programs like TRICARE. The TRICARE program and the issues that created this immense reorganization will be discussed. Chapter IV discusses the TRICARE management structure and outlines how working groups can be used to assist managers to implement change in an organization. Chapter V contains an analysis of TRICARE's use of working groups and Chapter VI concludes the thesis with conclusions and recommendations.

II. HISTORY OF MEDICINE

A. DEVELOPMENT OF CIVILIAN HEALTH CARE

This section will provide a chronological account of the development of health care within the civilian sector from the 1700's to the present. It will show the cyclical pattern of medical emphasis, from family medicine to specialization back to family practice. The current need for general practitioners, or "family physicians" is shown by the increasing use of managed care or Health Maintenance Organizations. The preponderance of historical information contained in this section is taken from *The Social Transformation of American Medicine* by Paul Starr.

1. 1700's: THE FAMILY'S ROLE IN MEDICINE

In Eighteenth Century America, a physician practiced medicine in an extremely competitive environment, competing not only with other physicians but also with the family institution. Although a doctor's ambition was to develop a strong reputation and a close relationship with his patients, the family in early American society was the focal point of social and economic life. Women had the responsibility to care for the ill in her family. This family focus made it difficult for physicians to establish themselves as necessary agents to heal the sick. As the years went on, medical books

and journals were published and circulated around town to assist women in diagnosing and preventing disease for her family. Books such as *Domestic Medicine*, written by William Buchan, set forth in layman's terms information on current diseases and medical advice on preventive medicine. These types of books challenged the authority of medical professionals by alleging that families could care for themselves.

America, at this time, was a rapidly changing and expanding society. Professional physicians wanted to establish an elite and distinct society of professional doctors, similar to that of England. In England, not everyone could practice medicine. Physicians had specific requirements they had to meet to practice. Physicians in America also wanted to establish boundaries around the practice of medicine to prevent laymen from engaging in such endeavors. These boundaries included the requirement to earn a degree in medicine and obtain a license to practice. Unfortunately, the boundaries between profession and trade, physician and layman that so assiduously preserved the profession in Britain were not as clear in America. Gradually, Americans who were seriously interested in practicing medicine went to Europe for advanced medical education, since none existed in this country. This proactive movement towards establishing quality medical practices motivated local governments to protect the profession with legislative initiatives.

One such initiative occurred in 1765 when the first medical school was chartered at the College of Philadelphia in Pennsylvania. Although few schools existed at this time, many physicians hoped that by establishing medical schools in America, they would be able to create for themselves a respected profession. Initially, medical schools offered both bachelor's and doctoral degrees in medicine, but it soon became clear that most students graduating with a bachelor's degree did not return for their doctorate degree. Since most doctors felt confident practicing medicine with only a bachelor's degree, the status and respect that might be gained with advanced education was not realized. Although physicians wanted boundaries set for practicing medicine, the American government, with its massively expanding population, did not have the political means to enforce many requirements.

2. 1800's: THE GROWTH OF PROFESSIONAL MEDICINE

As America grew, people's social and economic life styles changed. The tightly knit family circle that once centered on a small piece of land started to change. Family members began moving out of the area to start a new life on their own. As the family became more geographically separated, they lost their close bond during times of illness. People conversely became more dependent on the physician for medical care. The relationship between the doctor and his patient began to grow strong.

At the turn of the century another change was also starting to take form. The social distance between the doctor and patient started increasing while the rapport between practicing physicians grew closer. The government finally recognized the medical profession as legitimate, and boundaries to protect their practice were beginning to be enforced.

Unfortunately, American hospitals at the start of the nineteenth century were considered dangerous places to go if you were sick. They were viewed as institutions for the mentally ill, not the physically ill. Many felt it was safer to stay at home with your family and wait for the family doctor to make a house call. Consequently, hospitals were rarely used for treatment of the physically sick. In addition, the levels of medical technology were very elementary compared to today, and most everything that could be done in a hospital could also be done in the home during a house call. Most people who resided far from town did not seek out doctors for treatment of their ills, and unless doctors made house calls, traveling to a doctor's office could mean an entire day's work lost for the patient (during the 1800's, paid sick days were not a benefit given to workers). Physicians, on the other hand, made valiant attempts to make house calls in hopes of reaching the people, curing the sick, and providing themselves with an adequate source of income. Because of the time required to travel from patient to office

to patient, physicians found it difficult to support themselves by practicing medicine as their sole source of income. Many local doctors were also the pharmacist, and surgeons were often the town barber. Autobiographies of doctors practicing medicine in the nineteenth century state that most of their day was spent traveling along back country roads, "half ... in the mud and the other half in the dust."

The "transportation revolution" in the mid-nineteenth century really benefitted the practice of medicine. The railroads brought patients into the city faster and cheaper. This made it easier for them to be treated by a physician. Street cars used in the cities saved valuable time for both the patient and the doctor. Doctors usually established themselves along street car routes making access easier. This "transportation revolution" helped physicians expand the territory that they could cover. Also, the telephone made its debut in the 1870's making it easier and more affordable to reach physicians. The first rudimentary telephone exchange on record, built in 1877, connected the Capital Avenue Drugstore in Hartford, Connecticut with twenty-one local doctors. Drug stores in those days were considered message centers for doctors. This transportation revolution also decreased the cost of medical care and put care within the income range of most people.

New technologies developed during the nineteenth century included advances in automobiles, hard roads,

telephones and railroads. This enabled physicians to cut travel time and allowed them to spend more time with their patients. It also meant less time out of a patient's busy day to visit the doctor. Cutting transportation costs (and time) directly raised the supply of physicians' services by increasing the proportion of the physician's time that could be spent with the patient.

The close of the nineteenth century saw a greater reliance on hospitals for providing medical care. Urban growth led to higher property taxes, and consequently, people in or near the city moved into smaller homes and apartments. Smaller places to live made it more difficult to care for the acutely ill at home. Many times, there was simply not enough room. However, the dangers of infection in general hospitals because of poor hospital hygiene led families to manage physical illness at home if at all possible. It wasn't until after the Civil War that hospital hygiene improved.

3. 1900's: THE EVOLUTION OF MANAGED CARE

As America entered the twentieth century, society transformed from a predominantly agricultural economy to a manufacturing economy. The manufacturing economy gave rise to big businesses over small, family-owned operations causing a shift in focus from the individual to that of institutional domination. [Ref 1:p. 3]

During the last fifty years, society in every developed country has become a society of institution. Every major task whether performance or health care, education or protection of the environment, the pursuit of new knowledge or defense, is today being entrusted to big organizations, designed for perpetuity and managed by their own management. [Ref 1:p. 3]

Simultaneously, in the medical arena, a historical transition from generalist to specialist occurred. This transition set the seed for corporate management of medical care. Specialized medicine quickly began to unfold during World War II. With the surge of new technology, physicians started to specialize in certain areas of medicine. There was an increasing emphasis on medical training and facilities, and physicians released from military service were taking residency in various specialties. At the end of World War II, practicing specialists started to flood the market as 100,000 medical personnel (not all physicians) were released from active duty during the post war downsizing. By 1966, almost 70% of all practicing physicians called themselves specialists leaving 30% as generalists.

Specialists began to practice in groups instead of working on their own. The costs of providing medical care, advances in technology, scientific evolution, and other economic forces were the main catalyst for this shift. Physicians began to purchase expensive equipment as a group rather than practice on their own and bear all the expense.

Managed medical care has been developing for the last 60 years, and group practice has evolved into popular marketable entities called Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO). These organizations, growing successfully on group payment and preventive medical care, inspired several prepaid group practice plans to evolve. From 1930-1960 these organizations prospered but not without opposition from organized medicine (such as the AMA). Even when direct service prepaid plans were controlled by physicians, the AMA disapproved of them as a form of unethical contract practice. In fact, the AMA, in 1937, opposed the Group Health Association in Washington D.C. so vehemently that they fought it in court by charging that it violated the Sherman Anti-Trust Act. When court action failed, they threatened reprisals against any doctor who worked for the plan, prevented them from obtaining consultations and referrals and succeeded in persuading every hospital in the District to deny them admitting privileges. This succeeded in cutting off group members of the cooperative from hospital care.

The Kaiser-Permanente Medical Care Program originated in 1942 and is considered, by far, the largest, most widely distributed and best known HMO in the country. [Ref 1:p. 4] An HMO is a delivery system with a mission to provide high quality health and medical services at a competitive price. *Competition* is the key variable in the mission statement. The

basic principles of management; planning, organizing, directing, controlling and coordinating all lend themselves to carrying out the stated mission through the use of alternative provider systems such as HMO's and PPO's. [Ref 1:p. 7] The Preferred Provider Organization (PPO), by definition, is slightly different from a Health Maintenance Organization (HMO). A PPO is "a contractual arrangement between professional and/or institutional health care providers and employers, insurance carriers or third-party administrators to provide health care services to a defined population at established fees." [Ref 1:p. 5] HMO's and PPO's represent a competitive form of bureaucratic organization in medical care. [Ref 2:p. 27] By mid 1979, there were 217 HMO's operating across the nation with a total enrollment of 7.9 million people. This figure had doubled in size since 1970. Clearly, a primary reason that HMO's have been so successful is that physicians have been able to accept some financial risk - the financial risk associated with providing medical care and services to a group of subscribers. Both profits and losses are shared by all the physicians.

As we move toward the end of the twentieth century, there is a growing concern that there are too many specialists and not enough generalists to provide adequate care for the nation at a reasonable cost. There is a strong consensus that primary care physicians are the foundation to an effective health care system. Current interest among physicians to

practice primary care is very low. One possible reason is purely financial; another is related to status. Specialists tend to make more money than generalists and their advanced training in a specialized field gain them more status as a physician. Almost all young internists today have their ambitions tied to becoming a specialist. The percentage of practicing primary care physicians is a staggering 32%. That leaves 68% of the physicians practicing in a specialized field. [Ref 3:p. 380]

In contrast to other industrialized nations, the percentage of specialist and generalist is balanced at 50%. Health indicators show that in comparing costs, other countries do as well or better in providing the care at lower cost. Additionally, the percentage of physicians graduating from U.S. medical schools who are declaring generalist fields has drastically declined from 36% in 1982 to 14% in 1992. This is significant to analyze since successful models for an effective national managed health care system requires a ration of 35% specialists and a 65% generalist physician distribution (see Figures 2 and 3). [Ref 3:p. 380]

The 1980's ended with the nation realizing the need to develop awareness and incentives for physicians to practice primary care, in general, and family care practice in particular. Major issues pertinent to family practice in 1989 include passage of Medicare physician payment reform and the development of student interest initiatives. These

**PROJECTED HEALTH CARE COSTS
FOR FY-93 (\$168)**

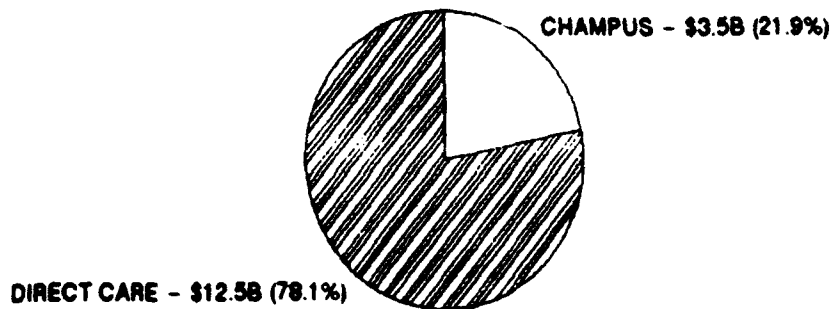


FIGURE 2

**DISTRIBUTION OF DIRECT
CARE COSTS FOR FY-93 (\$12.5B)**

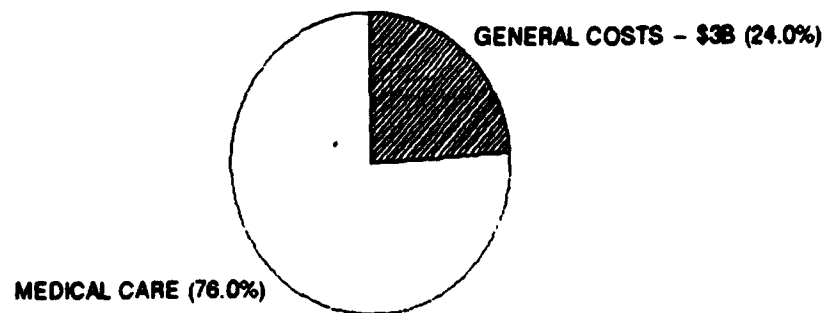


FIGURE 3

initiatives give financial incentive to students to become general practitioners, family physicians, etc. [Ref 4:p 2643]

As the 1990's begin to unfold, it becomes even more critical to promote student interest in family practice. This is particularly important as our society places greater emphasis on continuity of care, preventive medicine and health promotion. Unfortunately, 14% of graduating "generalist" medical students is far too few to meet expected demands for their services. Making the situation even worse, nearly 24,000 family and general practice physicians are now over 55 years of age and will retire in the near future. [Ref 4:p. 2643]

As we attempt to find ways to increase accessibility to care, reduce medical costs and continue to maintain high quality standards of care, increasing the number of primary care physicians is one solution. David Meltzer in his article *Are Generalists the Answer for Primary Care* identifies that use of primary care physicians with an emphasis on preventive medicine and health promotion can result in fewer emergent hospital admissions, shorter lengths of stay, lower medical costs, wider access to care, and overall greater patient satisfaction. Another solution could be to increase the specialists' function to include primary care. Specialists could then provide primary care/family care while treating specific patient problems as well. This would reduce the number of referrals, decrease multiple workups and ultimately

improve the continuity and coordination of care. Expanding primary care to specialists can be accomplished in less time than would training a new generation of generalists. [Ref 5: p. 1714]

It is clear that America needs to provide better primary care for its citizens. This is the objective behind President Clinton's new national health plan. As we collectively improve the nation's health care system, why not cultivate more specialists to practice primary care instead of training more physicians to be generalists.

President Clinton has launched a nationwide effort to find an acceptable new balance of competing public demands to reinvent health care in ways that provide somewhat less freedom for patients and doctors with more cost control while still providing quality care. Costs for health spending have been on the rise for at least four decades. Between 1965 and 1991 health spending has risen from 5.9 to 13.2 percent of the Gross Domestic Product. During the same time frame, health care costs have gone from 2.6 percent to 16 percent of federal outlays, and if no changes occur, could reach 25% by the year 2000. [Ref 6:p. 31]

The Department of Defense has also begun to pursue innovative approaches to reinvent their health care delivery system. There are various satellite projects ongoing throughout the United States such as the TRICARE Demonstration Project in Virginia. Reinventing the delivery of health care

is a major undertaking for any organization, especially the military. The remainder of this chapter will provide a brief history in chronological order of the practice of medicine in the military. It will focus primarily on the Navy's Military Health Service System (MHSS).

B. DEVELOPMENT OF MILITARY HEALTHCARE

This section takes a look at the development of medical practice first in the Navy and then within the Department of Defense (DOD). The history of Navy medicine begins in 1775 with the commissioning of the Navy's first warships. This discussion will develop into current trends in medical practice within the DOD.

1. History of Navy Medicine.

Navy medicine has progressed in much the same way as medicine has in the civilian sector. The mission of today's Navy Medical Department is to "ensure the health of our Navy and Marine Corps personnel so that they are physically and mentally ready to carry out their worldwide mission."

[Ref 7:p. 2] Today's Military Health Services System (MHSS) is a large, complex organization. It consists of over 400,000 personnel in the active duty, reserve and civilian workforce. It operates over 148 hospitals and medical centers and more than 800 medical and dental clinics all over the world. Total eligible beneficiaries total over 9 million people.

[Ref 8:p. 22)

Ever since 1775 when the Continental Congress commissioned its first warships, the Navy has provided medical support for its sailors and Marines. During that time, a civilian was appointed as ship's surgeon and was authorized for service on the ship. They were professional gentlemen, not officers and not sailors. Surgeons and surgeon's mates were hired simply for the duration of a cruise and discharged on its completion. They were tasked with only the immediate treatment of disease and injury. Their main goal was to keep as many crewmen as possible battle ready. [Ref 9:p. 10] In fact, between 1775 and 1842 there was no formal organization to sponsor and promote Navy medicine. In 1822, the first standards were established for entrance into the medical corps. Courses of instruction in naval hygiene and military surgery were developed for newly commissioned medical officers. It wasn't until 1842 that the Navy was reorganized and The Bureau of Medicine and Surgery (BUMED) established.

Prior to 1842, Navy medical personnel had limited status within the organization but no rank. Physicians began requesting what was called assimilated rank. They wanted to be commissioned as Navy officers with the rank of either Assistant Surgeon, Passed Assistant Surgeon, Surgeon or Fleet Surgeon. This proposal was extremely unpopular with the line officers who felt that their status as military officers was being jeopardized. In 1846, the Secretary of the Navy issued an order providing for assimilated rank. From then on,

medical officers would rank with line offices of comparable seniority, although their rank titles would be different. [Ref 9:p. 14-15]

The 1900's brought great organizational change within the medical department. Increased attention was paid to requiring inoculations for small pox and typhoid. Postgraduate and specialization training were instituted and greater attention was paid to infectious disease control and sanitation. In 1908 the Nurse Corps was established and in 1912 the Dental Corps. In 1940, with the authorization of a "two-ocean" Navy, the need arose for greater focus on logistics and medical supply, medical mobility, and casualty evacuation. Mobile field hospitals with anywhere from 10 to 3,000 beds were developed and staffed. Hospital ships were made to be as fully functional as a large shore-based facility. All major U.S. Naval vessels were embarked with full medical capability and even small vessels carried at least one corpsman on independent duty. Great advances in combat casualty care are clearly shown by their effects on survival: at least half of all men wounded in battle prior to World War I died from their injuries; during World War II, 98% of the wounded recovered. [Ref 9:p. 3]

During World War II the Medical Department grew from 13,000 to 170,000, but by July of 1946, 100,000 were discharged. One of the most important Navy medical initiative of the time was the establishment of the Medical Service Corps

in 1947. With the addition of nuclear weapons to many countries' arsenals, important advances were made in the areas of radiation exposure and health surveillance programs. Increased priority was also given to defense against injury by chemical, biological and radiological warfare agents.

The attack of North Korea across the 38th parallel in 1950 brought new difficulties for the medical department. After the post World War II downsizing, the Medical Department found itself preoccupied with peacetime hospital practice. An amendment to the Selective Service Act was necessary to provide enough physicians and dentists to support combat forces in Korea. Tri-service coordination was used to procure medical equipment and supplies and provide more effective operational and logistics support. Casualty survival rate again increased with the ability to provide a ready supply of whole blood and blood derivatives to combat areas. With the institution of the all volunteer military force after the Vietnam conflict, recruiters found their pools of physician volunteers empty. Because of this, the Armed Forces Health Professions Scholarship Program and the School of Medicine at the Uniformed Services University of Health Sciences were established. During the post Vietnam exodus of physicians, the Navy also found itself severely short of general medical officers and had to use specialists as generalists. To respond to the urgent need for more general medical officers (and provide for career advancement of senior

enlisted corpsmen), the Warrant Officer Physician's Assistant Program was established. To enhance physician retention, promotions were accelerated and special pay was increased. [Ref 7: pp. 4-5]

2. Current Trends.

Ever since the 1800's the Medical Department's funding has come from appropriations from the federal budget. Today, free health care for active duty military personnel is, by law, a right. Therefore, all care provided to active duty personnel comes through the direct care system (military treatment facilities) or is paid for by it. Dependents of active duty personnel are also eligible for direct care but only when such care is available. When care is not available, most non-active duty beneficiaries can use the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Those eligible to use CHAMPUS include active duty dependents and retirees under age 65, their dependents and survivors (active duty members are not eligible for CHAMPUS). Under CHAMPUS guidelines, if direct care is not available, beneficiaries are directed to see civilian providers with most of the costs being covered by CHAMPUS funds.

Defense health care costs are rising fast. In 1984, DOD spent approximately \$7.2 billion on military healthcare and in 1990 just over \$14 billion. In 1993, DOD will spend well over \$16 billion on military health care. Twelve and

one-half billion dollars will be spend on direct care. Direct care costs include pay and benefits of the military and civilian health care providers and the costs for operating and maintaining the direct care system. The remaining \$3.5 billion will be consumed by CHAMPUS. Nine and a half billion of the 12.5 billion direct care dollars are directly related to providing peacetime medical care to beneficiaries, and the remaining expenses are general costs associated with maintaining a medical establishment such as military construction or costs of having a medical supply war reserve (see Figures 4 and 5).

The Congressional Budget Office (CBO) predicts that, if no changes in military health care policies take place, health care costs will continue to rise over the next few years despite the drawdown in forces. Even if active-duty personnel are reduced to 1.4 million in 1997, peacetime health costs are still predicted to rise from \$9.5 billion in 1993 to \$11.6 billion.

During the current drawdown of military forces, more than 24 military hospitals are shutting their doors as the bases they are attached to close (this does not include clinics or small medical facilities). As direct care becomes less available as the number of Military Treatment Facilities (MTF) decrease, more beneficiaries are being driven into the civilian community for care. This is causing a direct impact on the number of CHAMPUS claims being filed. The number of

**CURRENT DISTRIBUTION OF
GENERALISTS TO SPECIALISTS**

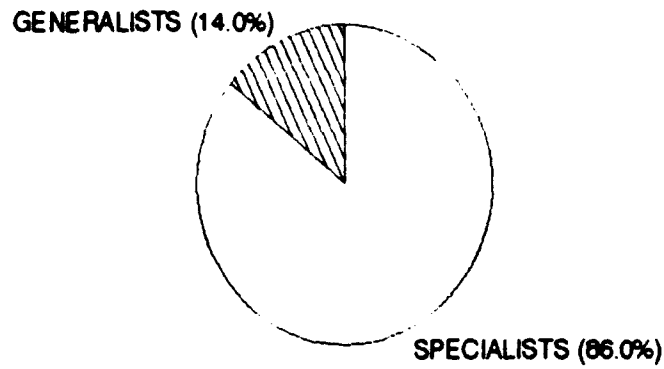


FIGURE 4

**OPTIMAL DISTRIBUTION OF
GENERALISTS TO SPECIALISTS**

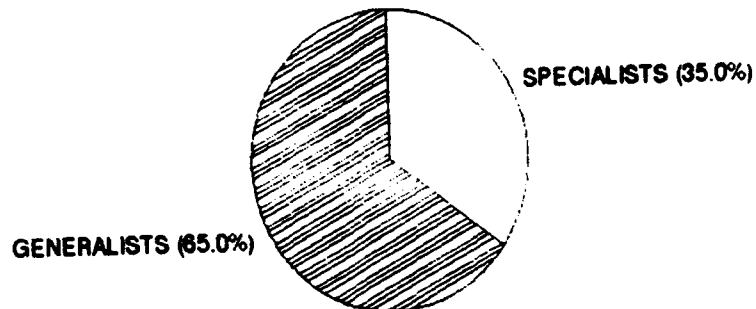


FIGURE 5

CHAMPUS users has dropped from 6 million in 1988 to 5.9 million in 1992. This is mainly due to the recent reduction in force and the associated decrease in military dependents. Although the number of users has decreased, the number of claims filed has increased by over 65% (see Figure 6). [Ref 11:p. 14]

NO. OF BENEFICIARIES vs. NO. OF CHAMPUS CLAIMS FILED

YEAR	NUMBER OF BENEFICIARIES	NUMBER OF CLAIMS FILED
1988	6,044,396	10,678,201
1990	5,923,822	15,470,799
1992	5,936,148	17,910,083*

*reflects claims processed through June 30,1993.

FIGURE 6

One way to control these rising CHAMPUS costs is to reduce the number of eligible beneficiaries. A second, more feasible approach, is to decrease the need to use civilian healthcare providers by improving the availability of care in existing MTF's. This would involve a new way of managing military health care and was the catalyst for the DOD's Coordinated Care Program (CCP).

III. THE DEVELOPMENT OF MANAGED CARE IN DOD

A. INTRODUCTION.

With the epilogue of the Cold War comes a new security strategy for the United States. This strategy requires all military services to join together and work as a cohesive group to conduct a new variety of contingency operations. The services need to understand that in order to meet the military challenges of the future, a joint strategy is imperative; a strategy that emanates inter-service cooperation. Consequently, joint ingenuity and action will be essential.

Current U.S. military doctrine addresses the need to focus on a variety of threats involving more numerous, less capable enemy forces. This is a vast change from the long standing doctrine which focused on a single superpower (primarily the former Soviet Union). With the active drawdown of U.S. military forces, the services must now be able to accomplish their missions with smaller forces and fewer bases.

Each service will be required to fight as part of ad hoc coalitions or to work with traditional partners outside existing alliance lines. In addition, mission requirements will be far more complex and diverse, running the gamut from disaster relief, humanitarian relief, nation assistance, and peacekeeping to forced-entry operations and high-intensity armored warfare all in a single theater of operations-all at the same time. [Ref 12:p. 56]

To compound these new mission challenges, all service departments are being given less money with which to operate (including the medical departments). With this in mind, highly trained forces, successfully operating at the lowest possible cost will be the military's key to success in meeting the needs of the nation's security.

This chapter will address three issues. The first gives a background of past and current trends in the strategy and mission of the Department of Defense and its current policy promoting joint operations. This discussion will include, but will not be limited to, military operations. It will then explore the emerging joint strategies and policies within the Department of Defense concerning health care and the operation of military treatment facilities. This chapter will conclude with a description of the TRICARE demonstration project.

B. BACKGROUND.

1. Joint Operations in Military Departments.

For the past 45 years military joint contingency operations were not conducted on a routine basis. Since the end of the Korean War, each military service has had clearly defined responsibilities and the strategic focus of each was explicitly recognized. The National Security Act of 1948 clearly spelled out each service's role - to man, train and equip forces to operate on land (Department of the Army), operate on and from the sea and conduct land operations

essential to Naval campaigns (Department of the Navy) and conduct offensive and defensive air operations (Department of the Air Force).

During the Cold War, the services developed habitual relationships with each other primarily due to the traditional, single strategic focus aimed at the European theater. It was then a predictable world of distinct threats and clear cut missions. A generation of soldiers, sailors, Marines and airmen became accustomed to the scenario of war against the Soviet Union. Most all efforts and training were centered on this Cold War posture. Navy officers knew the sea lanes of the North Atlantic inside and out. Likewise, Army and Air Force officers found little change in war plans by being assigned to the same bases in Europe over and over again.

Compared to the traditional Cold War, the current threat is not as clearly defined. The 1993 National Military Strategy of the United States sums it up best.

For most of the past 45 years the primary focus of our national military strategy has been containment of the Soviet Union and its communist ideology -- we met that challenge successfully. Over the short span of the past 3 years, the Berlin Wall fell; the Warsaw Pact dissolved; Germany reunified; democracy took hold in Eastern Europe and grew stronger in Latin America; and international coalition successfully reversed Iraqi aggression; and the Soviet Union ceased to exist as communism collapsed as an ideology and as a way of life. . . . Future threats to U.S. interests are inherent in the uncertainty and instability of a rapidly changing world.

-Gen Colin L. Powell, Chairman, JCS

The current U.S. military mission calls for a focus on a more diverse, flexible strategy. U.S. military leaders are actively pursuing innovative concepts that promote inter-service cooperation. "...From The Sea" is one such example. The white paper, signed by Admiral Frank B. Kelso II (Chief of Naval Operations) and General Carl E. Mundy (Commandant of the Marine Corps) charts out the Navy's new strategic concept for the 21st Century. Joint Pub 1, titled "Joint Warfare of the Armed Forces," specifically outlines the DOD's current guidance on joint operations as follows:

Joint Pub 1 guides the *joint* action of the Armed Forces of the United States, presenting concepts molding those Armed Forces into the most effective *joint* fighting force.

Service troops are being employed more and more under joint force commanders. Recently, Operations Just Cause and Desert Storm have shown that American forces can work jointly and be truly successful. Services have constructed joint committees to foster inter-service cooperation and eliminate barriers to joint inter-operability.

Unfortunately, habitual relationships that develop between individuals and groups can cause difficulties when those individuals or groups are asked to work outside their normal relationships. The U.S. military is no exception. Old habits are hard to break, and getting ships, planes, tanks and most importantly, service men and women to work together in

joint and combined operations cannot happen overnight. Contingency and daily operations with various pieces of each service, molded together should be the standard and not the exception.

Additionally, with the downsizing of the military and fewer defense dollars to go around, the services can accomplish their respective missions and national objectives collectively at a lower cost. Innovation can breed success that is also affordable. These successes not only serve the combat arms but can serve the military medical community as well.

2. Joint Operations in the Medical Community.

The cost of health care in the military has been increasing beyond what can be covered within budget constraints.

Military medical costs have risen twice as fast as any other military cost. One main reason: the armed forces and the Veteran Affairs having to pay increasingly larger amounts to private health-care providers now being used to supplement in-house military care. [Ref 13:p. 45]

There are three factors causing an increase in the use of civilian providers. These are: (1) closure of military hospitals, (2) decreasing hospital budgets, (3) and decreasing hospital staff. These three factors have caused access to direct care services to become severely limited. As a result, the military is being compelled to apply joint principles to

develop innovative ways to provide accessible, quality health care at affordable costs.

Another reason for the increased use of civilian providers is the increase in the number of dependent and retiree beneficiaries. One of the biggest changes in the last 25 years to effect health care delivery was the adoption of the all volunteer force. Prior to the 1970's, the military could more selectively choose its members and the force was composed predominantly of single men and women. Institution of the all volunteer force brought a much larger number of married volunteers. This resulted in an increased numbers of dependent beneficiaries. Along with this trend came an increase in the number of beneficiaries retiring from service during and after World War II and the Korean war. With the Reagan administration came a dramatic increase in the size of the military force and a corresponding increase in health care costs (more people = more health care required).

The Civilian Health and Medical Program for the Uniform Services (CHAMPUS) was introduced in the 1950's. Initially, CHAMPUS costs were relatively low because most beneficiaries were active duty and could be cared for using military direct care facilities. As the years went on, and the number of beneficiaries (specifically active duty dependents and retirees) began to increase, demand for medical care began to rise beyond the capacity of the military facilities. Up until 1987 referrals by military medical

commands to the civilian community under CHAMPUS were paid by the Office of the Secretary of Defense (OSD). Consequently, the military medical department neither incurred the direct costs associated with referring their patients to the civilian community nor saw the financial impact of it. As a result, each year OSD had to request additional funds from Congress to cover outstanding CHAMPUS bills. [Ref 14:p. 10] In 1988 Congress shifted responsibility for funding and paying CHAMPUS expenditures from OSD to each military service's medical department. Each service would receive annual CHAMPUS funding and be held responsible to live within their budgets and pay their own bills.

As a result of this change in fiscal policy, the military medical community was compelled to develop innovative approaches to providing quality health care while simultaneously bringing escalating medical costs under control. Since 1988, the medical departments have been experimenting with different programs to solve this problem. The most successful program implemented to date is the joint coordinated "managed care" program. The goal of this program is to integrate all health care services to improve access to high quality, cost-effective care.

C. TRICARE HISTORY

The first meeting of the Joint Services/Office of the Assistant Secretary of Defense Health Affairs Task Force for

Coordinated Care Operations took place in June 1990. This group specifically addressed the need to establish a managed care system in the Tidewater area. In September 1990, the initial meeting of the tri-service MTF commanders (at Langley AF Base, Fort Eustis and NMC, Portsmouth) took place to discuss the concept of establishing a coordinated cachement area management project in Tidewater.

Although this is the first truly tri-service coordinated care effort, there have been several other programs aimed at controlling growing health care costs. One of these is Cachement Area Management. Within the 1988 CHAMPUS reallocation, Congress authorized a Cachement Area Management (CAM) demonstration project aimed at controlling growing CHAMPUS costs. Five separate (single service) military sites were selected to participate in the 3-year CAM demonstration: two Army, two Air Force and one Navy. Four primary objectives of the project were to:

1. contain the rate of growth in CHAMPUS costs;
2. improve accessibility to health care;
3. improve satisfaction with health care; and
4. maintain quality of health care. [Ref 15:p.11]

Still other initiatives (all joint arrangements) include the Joint Military Medical Command in San Antonio, TX (Army-Air Force), the Delaware Valley Health Services System (DV-HSS) (Army/Air Force/Navy) and the San Francisco Medical Command (SFMC) (Army/Air Force/Navy). Although the DV-HSS and the

SFMC were tri-service, they were not managed/coordinated care programs. They still have long lists of sharing and cooperative efforts that serve as examples for others to follow.

To speed the progress of the TRICARE project, the Navy assembled a Rapid Implementation Team (RIT) in August 1991. Members of the team had expertise in the areas of communications, procurement, managed care and information systems. The RIT was comprised of nine military officers; seven Navy, one Army Reserve Medical Service Officer and one Air Force Physician.

On October 1, 1991, The Office of the Deputy Secretary of Defense (OSD) published a memorandum titled "Strengthening the Medical Functions of the Department of Defense." In this memorandum, he stated that

with increasingly tight constraints on resources available for the national defense, the Department must pursue aggressively actions to execute its vital missions more effectively, including its medical mission.

Also in this memorandum he directs the implementation of several new initiatives, one specifically being a Coordinated Care Program (CCP). The memorandum states:

The Assistant Secretary of Defense for Health Affairs shall implement a program to ensure coordination within appropriate geographical areas of the provision of medical care in DOD facilities with the provision of medical care through the Civilian Health and Medical Program of the Uniformed Services. The objective of the program shall be to maximize cost-effectiveness in the delivery of high-

quality health care in the accomplishment of the Department's medical mission.

Less than one year later, on August 14, 1992, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) published "Policy Guidelines On The Department of Defense Coordinated Care Program" which describes the CCP as a program that

will enable the DOD and the Military Departments to better accomplish the medical mission by improving beneficiary access to health care services, controlling health care costs, and ensuring quality care to all Military Health Services System (MHSS) beneficiaries.

Less than one month later, on October 1, 1992, TRICARE-Tidewater began operation as its three Service Centers opened their doors for business; one in Portsmouth, one at Langley AFB and one at Ft. Eustis.

D. TRICARE'S MISSION

TRICARE-Tidewater is a DOD CCP whose purpose is to optimize the utilization of the MTF's (NMC, Portsmouth; McDonald Army Hospital, FT Eustis; 1st Medical Group, Langley AFB) as well as a highly competitive civilian healthcare market in the Tidewater area. Their goals are to improve access to quality health care for all beneficiaries using the Military Health Service System (MHSS), enhance Graduate Medical Education and contain the increasing cost of CHAMPUS. TRICARE's health care delivery system is based on an HMO model

where patients are channeled to an appropriate level of care through the use of a "Gatekeeper" or primary care physician.

E. TRICARE AREA

The TRICARE cachement area is made up of a 40-mile radial area surrounding its three major medical facilities. These are the Naval Medical Center (NMC) in Portsmouth, VA, 1st Medical Group at Langley AFB, and McDonald Army Hospital at Ft. Eustis. This equates roughly to the area from Yorktown, VA to northern North Carolina and from the Atlantic Ocean to Richmond, VA. The Naval Medical Center, Portsmouth, located in Portsmouth, VA is the largest of the three facilities. It is a 446 bed tertiary care facility that sponsors many training, technical and graduate medical programs. The 1st Medical Group and McDonald Army Hospital are much smaller with 70 and 57 beds respectively. Average annual outpatient visits by facility are shown in Figure 7.

ANNUAL OUTPATIENT VISITS BY FACILITY

Service/Facility	Annual Outpatient Visits*
NAVY: NMC, PORTSMOUTH	1,253,000
ARMY: McDONALD	260,000
AIR FORCE: 1st MED GROUP	340,000

FIGURE 7

***Annual figures are for FY-91**

By virtue of the relative size of NMC, Portsmouth, the Navy has been designated "lead agent" for the project. In addition to these large medical facilities, several smaller clinics are part of the service area. These include Army clinics at Ft. Lee, Ft. Story, Ft. Monroe and Ft. Eustis; and Navy clinics at NAS Oceana, Dam Neck, NAB Little Creek, Northwest Security Group, Yorktown Naval Weapons Station, and Norfolk's Naval Base, Naval Shipyard and Naval Air Station. The Tidewater area was chosen as the first CCP site for many reasons. These include the large local beneficiary population, the in-house capacity of existing MTF's and clinics and the abundance of local civilian providers.

The Tidewater area has one of the largest populations of military health care (including CHAMPUS) beneficiaries in the entire Department of Defense. The local population is made up of approximately 381,000 beneficiaries (both active duty and dependent). They are broken up by service as shown in Figure 8.

BREAKDOWN OF BENEFICIARIES BY SERVICE

AIR FORCE	ARMY	MARINES	NAVY	TOTAL
45,662	46,993	10,354	278,072	381,081

FIGURE 8

Of these 381,081 beneficiaries, approximately 125,000 (33%) are active duty, 151,000 (40%) are active duty dependents and the remaining (27%) are retirees, their dependents and survivors. All are eligible for direct care (active duty have first priority, dependents second and retirees and their dependents/survivors third). Approximately 238,000 are eligible for CHAMPUS (active duty personnel and retirees over age 65 are not eligible).

The second reason the Tidewater area was chosen as the first CCP site is its ratio of population size to treatment facility capacity (comparison of supply and demand). Active duty military personnel are entitled, by law, to free medical care. It is also the policy of the medical department to provide all other eligible beneficiaries with free in-house care but only when space is available. Unfortunately, the demand for care in the area far exceeds the capacity of the local military treatment facilities. A study (simulation) was done to estimate the maximum capacity of the MTF's, shipboard medical facilities and clinics in the Tidewater area (shipboard facilities can only treat shipboard personnel). In order to show the magnitude of the shortfall, the beneficiary population was divided into two basic categories, active and non-active duty (see Figure 9).

BREAKDOWN OF BENEFICIARIES BY TYPE OF DUTY

ACTIVE DUTY	NUMBER OF BENEFICIARIES
AFLOAT	61,000
ASHORE	64,000
NON ACTIVE DUTY	256,000
TOTAL	381,000

FIGURE 9

The total estimated capacity of treatment facilities was also broken down into the three basic categories based on the type of facility. These are shipboard facilities, MTF's and clinics (see Figure 10).

FACILITY CAPACITY vs. FACILITY TYPE

FACILITY TYPE	CAPACITY
Shipboard	61,000
MTF's	92,000
Clinics	40,000
TOTAL	193,000

FIGURE 10

In other words, the existing network of military medical facilities can care for a maximum population of 193,000 individuals. The local beneficiary population is 381,000; 125,000 of which are active duty and have first priority for treatment. This leaves 256,000 dependent and retiree beneficiaries (381,000 total-125,000 active duty) to

compete for the remaining treatment capacity of 68,000 available appointments (193,000-125,000). This leaves, on the average, one available appointment for every 3 non-active duty beneficiaries. This shortfall in capacity decreases the morale of beneficiaries in the area because they sometimes spend hours on the phone trying to get an appointment. Additionally, it has increased the number of non-active duty beneficiaries that are forced to use CHAMPUS. Since CHAMPUS funds pay most of the cost of treatment from civilian providers, as availability of direct care decreases, CHAMPUS costs increase. Since one of the goals of CCP is to contain costs and improve access to the direct care system, the Tidewater area is an excellent candidate for this program.

Still another reason the Tidewater area was chosen for this project is its abundance of civilian health care providers. Within the 40-mile radius service area are nineteen general acute care hospitals, two children's hospitals, six psychiatric facilities and one orthopedic hospital. There is also an adequate supply of physicians representing all specialties. The hospitals in the Tidewater area range from 50-100 bed community hospitals to 500+ bed tertiary referral centers. The combined service offerings of these hospitals include all primary, secondary and tertiary services including trauma, open heart surgery, advanced cancer care, neonatal intensive care, burn care and transplant services. Practicing within the Tidewater service area are

over 2,300 non-federal physicians representing all specialty areas. They are predominantly solo practitioners with a small portion representing small, single-specialty groups. Four locally operated HMO's also exist within the Tidewater service area. Associated with these HMO's are over 3,300 physicians and 53 hospitals. Some, but not all of the associated physicians and medical facilities are located within the Tidewater service area.

The average local civilian hospital occupancy rates range from approximately 60% - 75%. Although percentages vary from hospital to hospital, most facilities within the service area can absorb additional inpatient capacity. These moderate occupancy rates coupled with the large supply of providers resulted in a highly competitive local health care market. As the laws of supply and demand apply, the DOD has an advantage in the Tidewater area. If local providers want to be a part of the Preferred Provider Organization (PPO) within the new TRICARE organization, they must be willing to negotiate rates which are lower than existing CHAMPUS rates. To date, most providers have been willing to do this as long as the rates can be tied to volume guarantees. This arrangement not only guarantees a regular supply of customers for the civilian physician, it provides the government with a significant savings over existing CHAMPUS fees.

F. TRICARE MANAGEMENT STRUCTURE

TRICARE's oversight responsibilities belong to the Navy as lead agent and more specifically to the Commander in Chief, U.S. Atlantic Fleet (CINCLANTFLT). The TRICARE Commanders' Board is responsible to CINCLANTFLT for planning, implementing, managing, and evaluating the CCP in the Tidewater area. The Commanders' Board is chaired by the Commanding Officer, Naval Hospital, Portsmouth and consists of the Commanding Officers of McDonald Army Community Hospital, Fort Eustis and the 1st Medical Group, Langley Air Force Base (in the immediate future, the Commander of the local Coast Guard facility will join the Board). The TRICARE Project Office is responsible to the Commanders' Board for the daily operations of the TRICARE project.

The TRICARE Project Office is managed by an O6 Navy Line Officer who serves as Director and is charged with the daily functions and operations of the TRICARE project. The TRICARE Project Office has five major departments. These are the Resources Department, Clinical Services Review Department, the Plans and Operations Department, the Marketing and Public Relations Department and the newest department, Information Systems.

G. TRICARE OPERATIONAL PLAN

TRICARE's operational concept is based on improving access to care by coordinating all of the medical resources of the

MTF and civilian providers. It is also based on controlling health care costs by providing beneficiaries with lower cost alternatives to finance their medical expenses. Active duty personnel assigned to units in the Tidewater area will continue to receive their medical care from the MHSS. However, non-active duty beneficiaries in the Tidewater area will now have three managed care options available to them in addition to the direct care system. The three managed care options are; TRICARE Prime, TRICARE Extra, and basic CHAMPUS.

TRICARE Prime and TRICARE Extra offer beneficiaries a smaller cost share percentage than CHAMPUS (i.e., dependents of active duty service members pay 15 percent of the negotiated rate as opposed to CHAMPUS's 20 percent). TRICARE Prime provides the same benefits available under CHAMPUS with additional benefit enhancements. These enhancements include periodic examinations and preventive care procedures that are not covered under CHAMPUS. Beneficiaries wishing to use TRICARE Prime are enrolled into the program and required to pay an annual enrollment fee instead of paying the normal CHAMPUS deductible. Enrollees are given the choice of an individual provider, a group practice, a clinic, or a treatment site participating in the PPO as their primary care manager who will act as a "gatekeeper" for specialty referrals.

TRICARE Extra covers the same medical services as CHAMPUS. In addition, beneficiaries choosing this option receive

discounts for office visits and hospital inpatient care by using the PPO. Providers belonging to the PPO network offer predetermined rates lower than the CHAMPUS allowable rates. This plan gives the beneficiaries more freedom when choosing a provider as well as the financial plan because they do not have to enroll. Patients may choose to receive their care through TRICARE Extra, standard CHAMPUS, or the direct care system on a case-by-case basis.

If beneficiaries choose to use one of the TRICARE packages, they will be treated by a qualified health care provider that belongs to the Preferred Provider Network in the Tidewater area. The Preferred Provider Network as well as all the MTF's and clinics are integrated through the TRICARE Service Centers.

The Service Center functions as the hub of the managed care program in the Tidewater area. There is one Service Center located at or near each of the three MTF's. With a single phone call to one of these Service Centers, beneficiaries can schedule medical appointments in the MTF's, clinics, or at a civilian health care provider who belongs to the PPO network. Also, beneficiaries can receive information on medical benefits and assistance with medical claims and forms processing. The Service Centers can be the most critical component of the TRICARE program since it is the element with which beneficiaries will interact the most. However, for the overall TRICARE-Tidewater project to be

successful, TRICARE and hospital administrators must effectively manage the implementation of change within their organizations. They must employ change management techniques that will make the transition from the traditional delivery of healthcare to the managed care method as smooth as possible.

IV. ORGANIZATIONAL CHANGES AND THE TEAM APPROACH

There is nothing that can replace the special intelligence that a worker has about the workplace. No matter how smart a boss is or how great a leader, he/she will fail miserably in tapping the potential of employees by working against employees instead of with them.

-Ronald Contino, former Deputy Commissioner
New York City Sanitation Department

A. INTRODUCTION.

On October 1, 1992, the DOD medical community began an integral change with the implementation of its Coordinated Care Program (CCP). The CCP brings with it a significant, innovative change in the way DOD medical facilities operate. According to Richard L. Daft, author of Organization Theory and Design, for any new idea to be adopted by an organization, certain activities must be completed. If any elements are missing, the change process will fail. Among these elements are:

1. Identification of a Need,
2. Discovery of an Idea,
3. Adoption of the Idea,
4. Implementation.

A need exists when managers are dissatisfied with current organizational performance. In the case of TRICARE, a definite need existed since "managers" (beneficiaries, hospital administrators, Congressmen, ASD(HA), etc.) were dissatisfied with the performance of the military health care delivery system in general and specifically in the Tidewater area. Most of the dissatisfaction in the area had to do with patients' access to care. The medical facilities (hospitals, clinics, etc.) were so busy that it would often take the patient days of calling the appointment desk to secure an appointment. The phone was usually busy and when one did get through, no appointments were available in the direct care system. When this occurred, patients would have to go into the local community and use CHAMPUS providers. This not only caused beneficiaries to be unhappy, it also made the CHAMPUS bill rise every time civilian providers were used. Many beneficiaries were sufficiently disgruntled that receiving Congressional complaints on the quality of healthcare in the Tidewater area was not uncommon. One Project Office administrator explained the situation:

Access to care has been a real problem (in the Tidewater area), there were an awful lot of Congressional complaints in the past, access to care was a problem. . . . Call on Monday, first of all, you can't get through, and when you do get through, they tell you to call back next month. . . . What we're trying to do is to ensure that we just do what is necessary in order to get the patient well. . . . There are standards that would make sense, and of course, contain costs. . . . (W)e also have extremely high

administrative costs in this country. . . . What we need to do is to try to improve access to care, one of the major problems in the area, we want to contain costs and we want to maintain the same quality of care.

An *idea* is simply a new way of doing things. It can be a model, concept or plan and must have the potential to reduce dissatisfaction felt by "managers." In the Tidewater area, the Managed Care model is the *idea*. The idea to use the Managed Care model was not the choice of local Tidewater healthcare providers, but that of the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Orders were delineated from ASD(HA) to implement a coordinated care program. To assist area members in understanding and implementing this new idea, the Navy assembled a "rapid implementation team" (RIT) and sent them to TRICARE-Tidewater. Members of the RIT had expertise in the areas of communications, procurement, information systems and, most importantly, managed care. Since hospital commanders were now responsible for their own operating budgets, they needed a way to better use their resources to improve the quality of care. Managed Care was the vehicle chosen for this. One hospital commander sees Managed Care as a good model to use to improve resource utilization and improve care. He said:

(O)ur budget's going down, the number of people we're taking care of is not going down; therefore, we've got to do something different. Managed care by, and all of its connotations, is the only thing we've got to do that. By

managed care I mean utilization management. I mean PPO's, HMO'S, etc., etc., etc. We've got to be able to do it better, and cheaper. And that's managed care, doing it better and cheaper. There is no other answer.

Adoption occurs when decision makers choose and accept a proposed idea to make a change. The adoption of this idea occurred on October 1, 1991, when the Assistant Secretary of Defense for Health Affairs published a memorandum titled "Strengthening the Medical Functions of the Department of Defense." In this memorandum, he stated that "with increasingly tight constraints on resources available for the national defense, the Department must aggressively pursue actions to execute its vital missions more effectively, including its medical mission." [Ref 15:p.1] Also in this memorandum he directed the implementation of several new initiatives, one specifically being a Coordinated Care Program (CCP) in the Tidewater area.

Implementation occurs when members of the organization actually use the new idea. It is the most difficult and the important step in implementing change. Unfortunately, many brilliant ideas are never used because they are never implemented. Quite often, managers fail to anticipate and prepare for resistance to change by consumers, managers and employees. No matter how impressive or logical a change initiative seems, it will no doubt conflict with someone's interests and jeopardize some alliances within the organization. If employees are uninformed or misinformed

about the proposed change, uncertainty about the impact the change will have on an individual's job, performance and career will most definitely result in resistance. [Ref 18: p.294] The TRICARE organization must apply appropriate change management techniques during this implementation period to minimize the negative effects of resistance.

This chapter will focus on the use of working groups as agents for change. It begins with a discussion of the management strategy that TRICARE chose to use and also a view of the supporting organizational structure they adopted. It will conclude with a discussion of TRICARE's use of the team approach as a mechanism for change.

B. CONTROL vs PARTICIPATIVE MANAGEMENT.

One item the TRICARE Commanders and the Project Office considered is the type of management strategy for their new organization. They could use either the traditional, military management strategy of control or they could view the new organization as a participative endeavor where people from all levels of the organization assist, innovate and contribute. The two opposing strategies, control-oriented and commitment-oriented (participative) are polar opposite. While control-oriented management strategy has distant ancestry in the bureaucracy of both the church and the military this type of management usually hopes for and achieves no more than mere compliance with standards. [Ref 16:p.78] Since the goals of

TRICARE (access, quality and cost containment) depend on a superior level of effort from everyone, it will require deep commitment to the cause, not mere obedience to rules and regulations.

In contrast to control, the goal of commitment-oriented management is to capitalize on the efforts of a workforce that is truly committed to the goals and aspiration of the organization. Managers have only lately begun to see that workers do not respond best and most creatively when they are tightly controlled by management, placed in narrowly defined jobs, and treated like unwelcome necessities. They do, however, work more productively when they are given broader responsibilities, encouraged to contribute, and allowed to take satisfaction in their work. It should come as no surprise that eliciting worker commitment (and providing the environment in which it can flourish) pays tangible dividends for the individual and for the organization. [Ref 16:p. 77]

During interviews with administrators in the TRICARE organization, I found overwhelming agreement with the commitment-based vice control-based strategy. Administrators of TRICARE do not simply want staff compliance with new organizational and operational changes, they want hospital, clinic and Service Center employees to feel truly committed to the project. One of the Project Officers in particular wants to make sure that each individual responsible for providing healthcare to beneficiaries enjoys their work and feels good

about what they do. He feels that there is a direct relationship between employee (provider) and customer (patient) satisfaction. He stated that:

. . . (O)ur basic philosophy towards our plan is we're going to make this thing fun for our people. There's got to be satisfaction for the staff. That's important not only for the TRICARE office but for the staff at the hospitals. If you don't feel good about what you're doing, if you don't feel right, then you don't really care much about providing hassle-free care (to the patient). . . The basic elements of TQL, whatever you want to call it, I think it works. If you get people to buy into the system, they'll make it work.

Another Project Officer believes that if workers are involved in operational changes, then they will feel more responsible for the product of their work. He feels that it is the Project Office's responsibility to provide the environment that will help the staff incorporate any changes into their daily routine. He believes that if they "own" the process, if they can personally feel good about what they do, then they will better understand why the change is taking place and be able to anticipate results of the change. The only means to this end is to allow the workers to participate in change implementation and change management. He stated that:

(t)he function of the TRICARE Project Office is to provide the environment, the supportive, facilitating environment where we can get these people (in the different hospitals) together. . . . We give them the opportunity to do well on their own. . . . You can order people to do anything you want, but it's better if they own it, it's better if they

understand it and can incorporate it into their daily lives. You can't force people to do those kind of things.

In support of this philosophy, TRICARE has organized several working groups throughout the organization to facilitate this change effort. Another administrator feels that

in the spirit of TQL, you want the people, . . . the people where the rubber meets the road doing whatever it is they are doing, you want them to make the decisions. They know better . . . because they know better day to day how to make the process better. That's why we have the working groups.

According to Harland Cleveland, former dean of the Humphrey Institute at the University of Minnesota and author of *The Knowledge Executive*:

In the old days when only a few people were well educated and 'in the know,' leadership of the uninformed was likely to be organized in vertical structures of command and control. Leadership of the informed is different: it results in the necessary action only if exercised mainly by persuasion, bringing into consultation those who are going to have to do something to make the decision work.

Physicians, technicians, nurses, and pharmacists are certainly not an uneducated group. They are the "informed" to which Cleveland refers. TRICARE administrators need to "bring into consultation" those that will be affected by the change to make the process go more smoothly. This was the basic philosophy behind the development of their working groups. These work groups are being used to bring members from the different services together to work on issues relevant to

TRICARE's implementation. As initiators of change, TRICARE administrators need the wholehearted commitment of others; involving them makes very good sense as participation leads to commitment, not merely compliance.

C. ORGANIZATIONAL STRUCTURE.

In support of their use of participative management, TRICARE must provide their employees with the ability to contribute to their own and the organization's success. The traditional military organization is a vertical structure which is heavily laden with rules, regulations and standard operating procedures. Each hospital within the Tidewater area (although each is run by a different military service) is structured in much the same way. In order to successfully implement the CCP, orientation must change from the traditional single service, vertical perspective to that of a multi-service, horizontally integrated approach. The traditional vertical structure can still exist within each medical department as necessary, but horizontal integration between the hospitals is essential if the services are to coordinate efforts to meet the established TRICARE goals.

The traditional vertical structure of any military hospital is depicted by its organizational chart or standard *chain of command*. The chain of command shows the vertical lines of authority from the Commanding Officer and links all personnel throughout the organization. In the traditional

(pre-TRICARE) sense, each hospital (NMC Portsmouth; 1st Medical Group, Langley; and McDonald Army Hospital, FT Eustis) has a separate chain of command, and the only way to cross organizational lines is up the chain to and through the Commanding Officers. Interservice communication was not standard practice because it was simply not necessary. One interviewee explained that communicating with his associates at the other hospitals was not common. He said:

Before (TRICARE), the Navy was here, the Army was here, the Air Force was here and everyone lived in their own little world. . . . I didn't even know the people at the other (hospitals) and they didn't know me.

This same opinion was expressed by nearly all the individuals that were interviewed. Each had little connection with other services because daily operations didn't require them to work together. Breaking this habitual, single service way of operating needed to be changed if a tri-service managed care operation could take place.

The structure of TRICARE must facilitate the communication among departments and employees that is necessary to complete its mission. Since the new CCP requires a tri-service perspective and interservice coordination, horizontal communication links that not only cross departmental lines but also cross service boundaries are essential.

Although the vertical chain of command structure is the traditional form of military organization, implementation of

the CCP requires the addition of a more horizontal dimension. Use of horizontal communication can assist the organization in overcoming barriers that exist between departments, or in this case, between the hospitals and services. TRICARE, headed by the TRICARE Commanders' Board (Army, Navy and Air Force), involves the delivery of health care in the Tidewater area through a coordinated effort by all three service hospitals, clinics, the VA and their established network of civilian providers. Achieving the desired level of interservice cooperation can be done in many ways, one of which is to establish task forces, or interservice, interdepartment working groups.

TRICARE administrators wanted those who do the work to have a voice in implementing the changes that affect their specific department or division. In support of this position, workers must be given a way to easily coordinate with their counterparts in the other medical facilities. It was for this reason that the Federal Working Groups were formed.

D. WORKING GROUPS.

This section presents a discussion of the benefits of using working groups as agents to aid in the implementation of organizational change.

J. Richard Hackman, author of *Groups That Work (and Those That Don't)* describes three characteristics that define work groups. These characteristics are:

- Groups are intact social systems, complete with boundaries, interdependence among members, and differentiated member roles.
- Groups have one or more tasks to perform. The group produces some outcome for which members have collective responsibility and whose acceptability is potentially assessable.
- Groups operate in an organizational context. They manage relations with other individuals or groups in the larger social system in which the group operates.

According to Hackman, effectiveness can be measured using a three-dimensional scale. The first measure is the degree to which the group's productive output (product, service, or decision) meets the standards of quantity, quality and timeliness. In other words, if a group generates output that is completely unacceptable to the individual(s) who receives the output, then it would be hard to argue that the group is effective. The second measure is the degree to which the process of carrying out the work enhances the capability of members to work together interdependently in the future. This measure is especially important to TRICARE since its whole operational concept is based on interservice cooperation. Groups can generate mutual antagonism so high that it becomes virtually impossible for those group members to work together again. Other groups become highly skilled at working together which leads to increasing levels of performance over time. The third and final dimension is the degree to which the group experience contributes to the personal growth of team members.

1. Enabling Conditions.

To perform well, all groups have hurdles they must surmount. Among these, each individual must: (1) exert sufficient effort to accomplish group tasks, (2) bring adequate knowledge and skill to the group and (3) employ appropriate task performance strategies. Using these criterion, if a group is not doing well, one can readily ask, "is it an effort problem, a talent problem or a group strategy problem?"

Another item that impacts group effectiveness include organizational conditions such as group structure (task structure, group composition), organizational support and reinforcement (including reward systems, educational systems and information systems) and expert coaching and process assistance to maximize effort, commitment, knowledge and skills. Effective groups require organizational support. Groups (not individuals) should be provided with reward systems as performance incentives, educational systems such as professional and interpersonal team training and adequate information systems to collect and process information essential to task assignment. They should also be provided with enough material resources such as equipment and space to accomplish their goals.

2. Task Cohesiveness and Commitment.

The specificity of group goals and accuracy of performance feedback have been found to increase work group cohesiveness. Also, cohesiveness has been positively linked to performance. Cohesiveness that is based on how attractive the task is to group members can lead to improved commitment to group goals, coordination through common understanding and levels of participation in the group process. The size of the group can also affect the group's effectiveness. O'Reilley and Roberts (1977) examined the effectiveness of 43 small to medium-sized groups with between three and 53 members. They concluded that:

as groups size increased, the possibility for group connectedness decreased because of limitations on the amount of effort that an individual can spend interacting with an increasing number of others.
(p.677)

Groups should be small enough to facilitate interaction among its members but contain a sufficient number of members to ensure all interested parties are represented. Groups should include members who possess adequate task and interpersonal skills and contain a good mix of individuals who are "neither so similar to one another that they are like peas in a pod nor so different that they have trouble working together." [Ref 19:p.499]

As well as group size, organizational integration is also an important factor in a group's potential for success.

The higher degree of required external integration, the more group effectiveness depends on the pace, productivity and workload of others. If the pace of outsiders is good, group effectiveness can be positively influenced. But if it is poor, a group's progress and reputation can suffer through no fault of their own.

Hackman identifies five common mistakes or "Trip Wires" that cause group effectiveness to falter. They are:

- Designers of work groups call performing units a "team" but treat and manage members as individuals.
- Managers do not maintain an appropriate balance between authority maintained by them and authority given to the team.
- Management assembles a large group of people, tells them what is to be accomplished with only general details and lets the "work out the details."
- Managers specify challenging team objectives, but skimp on organizational support.
- Group designers assume that members already have all of the competence necessary to work well as a team.

Maintaining a balance of authority may seem contradictory to the participative approach. Although exercising too many constraints on the teams can be counterproductive to their purpose, giving them too much authority or too little direction can also limit their effectiveness. [Ref 19:pp 493-504]

TRICARE's decision to use working groups to aid in the implementation of their immense organizational change has

proven to have some very positive effects on the organization. The remainder of this thesis will contain an analysis of data collected during interviews with members of the TRICARE Project Office and numerous members of TRICARE's working groups. Conclusions and recommendations will then be outlined based on the results of the interviews and the analysis.

V. DATA ANALYSIS

A. INTRODUCTION.

In February 1993, five Federal Working Groups (FWG's) were officially chartered by the TRICARE Commanders' Board to facilitate horizontal communication and encourage cooperation between the military services and the Veterans' Administration (VA). The principal objective of this program was to maximize the use of federal healthcare resources through sharing between the VA and DOD. The VA was included in TRICARE Federal Working Groups in support of the DOD Health Resources Sharing and Emergency Operations act of 1982 (10 U.S. Code 1104) and because they provide another resource with which to share, and offer new ideas. Cooperative efforts between the DOD and VA can significantly contribute to improving the provision of healthcare in support of TRICARE's goals of improved access, quality and cost containment.

To date, TRICARE has formed five working groups. They include the Laboratory, Pharmacy, Shared Procurement, Information Systems, and Staff Development groups. To ensure group and individual anonymity, they will be referred to as Teams Alpha, Bravo, Charlie, Delta and Echo (not in respective order). Both men and women from these groups were interviewed

as part of the research, but all individuals will be referred to as "he" in an attempt to ensure anonymity on the part of the interviewees.

The FWG's are comprised of various representatives from the different medical facilities (hospitals, clinics, administrative offices and the VA) and are tasked with investigating specific issues to improve the provision of healthcare under the new TRICARE organization. In February 1993, five FWG's were officially chartered, and the groups were asked by the Commanders' Board to formalize their mission/efforts. At that time, the Commanders approved the respective mission statements and memberships in an attempt to empower the groups and their members. One Project Office administrator explained that the TRICARE Commanders' Board and Project Office Staff wanted:

everyone to be able to work through problems on their own. We oversee what they are doing, but if anyone knows how to make good changes at the working level, it's the workers. We don't want to make changes that we think will make their jobs easier, because we don't really know what they do day to day. They know how to make the process easier because they work the process. They know how to better work together because they're the ones working together. That's what we're about. . . . You can order people to do anything you want, but it's better if they own it, it's better if they understand it and can incorporate it into their daily lives. You can't force people to do those kind of things.

Although the Federal Working Groups were only officially chartered in February, 1993, the idea of using working groups began in Tidewater approximately two years earlier.

The three hospital commanders originally began meeting together in about 1988 to talk about ways they could help each other solve common problems. They did not get too involved in sharing or contracting, it was just exchanging information and talking. They discussed the idea of getting groups of people from each facility together to meet and talk about how they could better use their collective resources and share information and ideas to work more efficiently. It was from those discussions that the tri-service working groups were established.

1. Team Alpha.

Team Alpha was the first group to be formed. Members were comprised of the heads of Alpha Department in the various medical facilities. Group members first began meeting because they felt that savings and improvements could be realized from such a venture and could easily be evaluated through material measures such as dollar savings, less material waste, equipment utilization, etc. They have been meeting for approximately two and one half years.

2. Team Bravo.

Team Bravo was the second group to form and was formed shortly after Team Alpha. Members of this group were comprised of the heads of Bravo Department. Like Team Alpha, this group got started because of expected cost savings as a result of the departments working together. Both Team Alpha and Bravo were formed prior to TRICARE's implementation. One

group member of Team Bravo conveyed his recollection of the roots of his group:

(We started meeting) about two and a half years ago. (I)t was decided by the directors of the hospitals that it was necessary for all the Chiefs of Services to get together and identify opportunities to save money and share resources.

The Chiefs of the Alpha and Bravo services were contacted and each tasked to meet in a working group.

3. Team Charlie.

Team Charlie was formed and met for the first time in January 1993. This group was established to provide a means for the various facilities to share specific non-material resources. Since resources in this group are non-material, evaluating group "success and effectiveness" is not as easy as measuring cost savings or waste reduction. During their first meeting group members introduced themselves to each other and discussed what they all did during their regular workday. They then proceeded to brainstorm ideas for topics they wanted their working group to address. They planned to prioritize the list at their next meeting and discuss each item further. Their next meeting was cancelled due to inclement weather, and each meeting since has been cancelled because a quorum could not be reached (due to apparent lack of interest on the part of one or some group members).

4. Team Delta.

Team Delta has been meeting for approximately two years. These group members began meeting because of the anticipated cost savings that they thought could be realized by consolidating the efforts of the multiple facilities. They have several issues they are working on that they believe will result in cost savings, however, a high turnover rate in the group has detracted from the group's effectiveness.

5. Team Echo.

Team Echo has been meeting for approximately one year. This group's goal is to improve efficiency and facilitate communication and the easy exchange/sharing of information between agencies (DOD and VA). Like Team Charlie, measuring this group's effectiveness (efficiency) is not as easy as using material measures (dollars, cost per unit, etc.). Poor attendance at initial meetings has slowed this group's progress.

1. Group Membership Criteria.

All five working groups were formed from similar departments within the MTF's, clinics and the VA. For example, the Information Systems Working Group is comprised of representatives from each information systems department, Shared Procurement members are from the logistics/materiel management service, etc. Individuals from the VA became involved in the groups in support of the VA and DOD Health

Resources Sharing and Emergency Operations Act. Each medical facility has at least one member permanently assigned to the group with some facilities having more than one. Membership selection for these groups was based solely on the individual's position in the organization. This approach was selected because administrators wanted the groups to be comprised only of individuals who had decision making authority. They did not want group members to be concerned with whether their boss would agree with recommendations or with members having to ask their boss for permission to do anything.

2. Group Missions.

Members of the working groups were tasked by the hospital commanders to discuss ways to overcome problems that would keep them from being able to work collectively and cooperatively. One member recalls their first meeting:

At our first meeting we had a brainstorm session to see what types of problems we would have to solve if we were going to be able to cooperate and work together.

To be able to effectively work together as a team, members at the different medical facilities felt that they had several hurdles to overcome. These hurdles include:

1. Geographic separation,
2. Being able to increase departmental/divisional efficiency without an associated increase in resources and (do more with less),

3. Overcoming the habitual single-service mindset and traditional ways of doing business.

All working group efforts address concerns in these three basic areas. Group efforts have all been directed toward clearing these obstacles.

B. FWG's - WHAT'S WORKING

During the course of this research, several positive issues surfaced as a result of working group efforts that have significantly contributed to the success of TRICARE. They are:

1. Many group members feel that as a group they are working well together and are proposing good ideas to the Commanders' Board that will help them work jointly.
2. Several working groups have come up with proposals that they feel will help bridge the geographic miles between them.
3. Working groups have found (and implemented) ways to break tradition, coordinate their efforts, better utilize their collective resources and save money.
4. Use of the working groups has increased horizontal communication among the various agencies.
5. Group efforts are assisting the DOD and VA in finding ways to better share their collective resources.

All of these issues assist in breaking down the barriers mentioned in the previous section and will be addressed one at a time.

1. Working Well Together.

Teams Alpha and Bravo had great success coming up with ideas and suggestions to overcome the aforementioned barriers of geographic separation, efficiency, and communication. Their relatively quick success began with their very first meeting. The relative ease with which these groups began was a key factor in their motivation and feelings of success. During interviews, members of these groups all mentioned that they had no trouble getting started. From the first meeting, group members all got along and ideas for discussion topics came very easily. Some group members recalled having positive feelings about the first few meetings of their respective groups:

Things took off very quickly, we were glad to meet. We would meet at the different facilities, not in the same place all the time. We would have lunch meetings at the different Officers' Clubs, too. The group meshed quickly and worked well together.

(We had) a brief on TRICARE and how it was going to work. Then we had a brainstorming session to see what issues we needed to discuss. No one was shy, and we all had some good ideas. The joint purchasing idea came up first, then the reference testing - the civilian lab services - , and the workload sharing came from that. Then all of that led to the transportation issue. If we were going to share work and resources, we had to have a way to get it back and forth. I think we all left that first meeting feeling like we had some good ideas to work with and something that was going to help us work together.

For one group, by meeting at lunchtime, not just in meeting rooms, it became an enjoyable experience, not just work. Every member of Teams Alpha and Bravo that was interviewed had

the same opinion. They have been busy at every meeting, have had many excellent ideas and have already sent proposals and recommendations to the Commanders' Board for consideration. When asked why they thought they had "instant success" as a group while some others were having difficulty, the predominant opinion was that they initially got together just to talk about things. They were already meeting when the TRICARE Commanders' Board directed the FWG's to meet. One individual explains this feeling:

We were asked to meet and see what we could do. We, I guess I shouldn't speak for everyone, I didn't feel like anyone was making me do anything. We were doing it for ourselves. We weren't forced to look at anything in particular. I guess it was just not a lot of pressure or coercion on us. I could see that this could really help me out so I had a personal interest in it.

Team members believe that when they started meeting there was no "corporate pressure" to get specific issues resolved. They were just out to look for issues that could help them share and work together more easily. They were meeting to see what they could do for themselves and for each other, not to see what they could do for TRICARE. One member from Team Bravo felt that since everyone wanted to accomplish the same thing (share services/resources), they all had the same vision for the direction of the group. There was no dissention among the ranks as far as what to discuss.

Well, it started out as "How can we share services with each other?" At one of our first meetings, we discussed (how) to share resources and services. . . .

One Team Alpha member agreed. He thought they meshed easily because "everyone came together with the same idea. The key thing for all of us was sharing resources." Also, since the groups' main focus was centered on the department that group members were in charge of, they all had a personal interest in increasing efficiency and saving money. In addition, improvement within each department could be easily measured in much the same way (dollars, materials, reduced waste, etc.). The units they dealt with were the same and could be materially measured using numbers and dollar figures. For example, when the laboratories had more tests than they had the capacity to complete, they would send lab samples to civilian test facilities for processing. By sharing laboratory facilities, many members stated that they have not had to use civilian facilities as much, thus saving money for the hospital or clinic. One individual in the Laboratory group, when asked if the group's efforts had made his job any easier, he said that it wasn't easier except that "some tests that they do for us now at the VA we don't have to send to the reference labs" anymore. This equates to real dollar savings - a material measure of success that is easily seen and recognized by everyone. It is something of which group members can be (and are) proud.

One member of the Laboratory group feels very successful because his boss has noted an increase in their service's efficiency.

(My boss) has no problem with me being on the team. As a matter of fact, we're getting more tests done at no more cost and that looks good for all of us. It's really made the workload easier because we're sending tests to Hospital A (that we would normally send out to have done).

Before establishment of the working groups, hospitals and clinics did not share testing facilities or do much of anything for each other. If tests couldn't be done in house, they would be sent out to a civilian reference lab for processing. Now, as a result of the cooperative spirit brought on by the working groups, individuals are more inclined to share their collective resources.

Another group member felt a great feeling of satisfaction not with any material measure of success, but simply because the Commanders' Board liked his group's ideas and suggestions. When asked when he remembered feeling most satisfied after a meeting he said:

I don't remember the date or anything, but it was when we had come to a point when we made our first recommendation to the Commanders' Board. I remember when we found out that he liked it we were really excited - I was really excited. I really felt that all of our work and time was worth it, that the Commander really liked our recommendation.

Motivation for this member was brought on by the recognition of superiors of the efforts of himself and his group. This

recognition can be just as important as success brought on by measured improvement.

One member of the Pharmacy group conveyed an obvious feeling of satisfaction that the collective pharmacies had a noticeable decrease in wasted materials. This happened because the different hospitals began sharing with each other (instead of throwing away) things they could no longer use. Since drugs have a limited shelf life, when they expire they have to be thrown away. The Pharmacy group now shares drugs with each other that are coming close to their expiration date. The head of one of the pharmacies explains how they have saved money by reducing waste:

(We identify) short dated drugs and share them instead of throwing them away. We circulate a list now of short dated drugs (that are ready to expire) and if anyone wants them they can come pick them up instead of us throwing them away. It works the same at the other places. There's no charge for this, it just cuts down on waste. I think it's saved the four hospitals around \$100,000 per year. Not each hospital, but in total.

In the past, these materials would be disposed of when they expired. By participating in the working groups, members are becoming more cooperative and willing to share with each other. These real time, easily seen and understood measures of success have helped the teams see progress, stay motivated and continue to meet, work and improve operations.

2. Geographic Separation.

Dealing with the extensive geographical distance between the facilities is a main concern of hospital and TRICARE personnel and is one of the problems that the FWG's set out to solve. Traditionally, if one of the medical facilities needed to get patients or goods from one hospital/clinic to another, they would send a courier themselves or run a shuttle. All of the groups decided that if they were going to share resources, they needed an easier way to get materials back and forth. One specific idea the groups came up with to bridge this distance is to contract a civilian transportation/courier service that would link the three hospitals, all of the clinics and the VA together. This service would allow the facilities to seem less geographically separated and better able them to transport patients or material goods (X-Rays, lab samples, paperwork, drugs, etc.) they needed to share. One individual on Team Bravo conveyed the birth of the idea:

We came up with four (ideas) that we have been working on. The first is a transportation service. If we are going to cooperate, we need to have a transportation service between the hospitals and clinics. . . . When we first thought of it, we wanted a courier service for (our department) only. Then as discussion developed, it was a better idea to share the service with others . . . for paperwork, patients, whoever needs to use it. . . . If we were going to share work and resources, we had to have a way to get it back and forth.

It is quite interesting to note in this interview excerpt that at first, even as a group, they were only looking out for

their own interests. They wanted the service only for their group to use. After talking it over, they decided that there was more sharing to be done among the facilities than just among themselves, so they then decided to involve other departments in the proposal. They knew it would take longer to offer participation to other departments, but they felt that it was the best thing for TRICARE as a whole. Not only have they changed their traditional mindset to work with each other as a group, the groups are also starting consider the needs of other groups and see the big picture of the tri-service cooperative effort.

This transportation service has many expected benefits to TRICARE. Sharing among the services and the VA involves more than simple talking during working group meetings. It involves the sharing and exchange of actual goods and services that will increase the overall efficiency of the Tidewater area healthcare system. If laboratories are to use their collective resources to get the most done at the least cost, it seems logical to have an easy way to get test samples from place to place. If the pharmacies are to share short-dated drugs, they need a way to be transported also. Also, since the DOD and VA do not share a common information system, a transportation service could also be used to transport copies of contracts, and other information that needs to be shared. One way to get items back and forth would be for each facility to drive items to the various hospitals themselves. This is

both time consuming and a great duplication of effort. It also wastes time out of a productive workday because it takes people away from their regular jobs to make deliveries and pick-ups. Having a courier service would simplify the sharing process while leaving hospital employees to work a full day. Other benefits of the transportation service include sending patient records, X-Rays, etc., to different facilities for consult/second opinion, or sending copies of procurement contracts, proposals, MOU's, etc. for review by other agency departments.

One group member was more than willing to look into details including prices for contracting a civilian courier service. He quickly volunteered his services to the group:

I told them at one meeting that I would contact some professional courier services for prices. It would include all of the (hospitals and) satellite clinics. Once I brought that information back, we put it together and sent it up to the Commanders' Board as a recommendation with all of the figures for setting it up.

This was one groups' initial success with having a recommendation accepted by the Commanders' Board for further consideration.

This is considered by all of the groups to be a critical element in allowing considerable sharing to be done among the services and the VA. Evidence of this is that other groups were also discussing the same issue at their meetings. Many group members emphasized the importance of the transportation

issue during their interview and expressed that it was a critical component of their sharing effort. Once the proposal was made, the issue was given to the Project Office for further research and implementation. Group members are now waiting for a survey to be completed and a contract to be awarded. They are anxiously awaiting the final implementation of this proposal.

3. Breaking Tradition.

Use of the working groups has helped members break the traditional "every man for himself" mindset between the military services and the VA. Each hospital has traditionally been run by its respective service and asking for or providing assistance to another agency wasn't standard operating procedure. One individual recalls how he (and each agency) normally kept to themselves:

Before this, the Navy was here, the Army was here, the Air Force was here and everyone lived in their own little world. Before this, I didn't even know the people at the other (hospitals) and they didn't know me.

Changing people's thinking from the traditional single-service way of doing things to having a more joint, cooperative effort is one example of how working groups have been successful. Three examples of groups finding ways to break tradition, coordinate their efforts and better utilize their collective

resources are creating an ad hoc transportation service, combining buying power and eliminating duplication of effort.

a. Transportation Service.

One example of the positive influence of working groups in breaking tradition is an ad hoc transportation service that was created and is currently being used by one of the groups. Before any "official proposal" was made to the Commanders' Board requesting to contract a civilian courier service (described in the previous section), the members of one team, in the interim, tried to work something out and set up a temporary courier service among themselves.

One of the hospitals had been running a shuttle to transport patients from their hospital to others long before the joint courier venture was even thought of. In the spirit of true cooperation, he offered the service to other members of his group to transport the items they were trying to share. Although this cooperative service was only meant to be temporary, it is providing a vehicle to get lab samples, paperwork, pharmaceuticals, patients, etc., back and forth between the different hospitals and clinics. This individual explains his proposal:

My hospital and lab are small . . . so we asked Hospital A if they could do some tests for us. My hospital has been transporting patients . . . for follow up on things we just can't do here. I had been using our Patient Transport to shuttle test stuff (of mine) to the different hospitals. So at one of the meetings after we discussed needing a shuttle service,

I offered the service I was using to everyone. The van goes to the (different hospitals) and picks things up.

Prior to this member's involvement in the working group, he had a shuttle service that only his hospital used. Until he became involved in the working group, he hadn't offered its use to anyone else. His involvement in the working group has changed his way of thinking from a single service view and has provided the catalyst needed to inspire multi-service cooperation. Group members are already seeing the benefits of being able to transport items back and forth. As discussed in the previous section, short-dated pharmaceuticals are being shared as well as lab samples being transported for testing at other facilities. These arrangements have resulted in real cost savings and increased efficiency.

b. Group Purchasing.

The traditional means by which each facility purchases supplies and services has also changed as a result of working group efforts. Different groups (not just the shared procurement group) have begun to coordinate their efforts to get better prices in the open market. As any consumer knows, most merchants give discounts for volume purchases. So, if one hospital can get a discount for buying in bulk, wouldn't a bigger discount result from four hospitals

purchasing together? This is the working groups' philosophy of combining procurement actions among the various agencies. Most of the groups have found ways to save money by combining their buying power.

One example is the Laboratory group's efforts to combine their contracts with civilian laboratory testing facilities. Currently, all of the laboratories are paying different prices for the same tests because each facility's contracted volume is different - price per test varies with volume. Group members decided that since everyone contracted at least a portion of their lab tests out of house, they could all get the maximum discount if they acted as one purchaser. One group member explains the idea:

Well, no way do we have enough resources to do all of the tests that need done in-house, so we contract with civilian labs to do some of them. Just like buying supplies in bulk, we want to contract in bulk too. Right now we are all paying different amounts for the same tests because we all have different quantities that we contract for. We're looking at working volume discounts for all lab work for everyone.

This innovative way to contract is definitely a new way of doing business for all involved. The same tests are being done as before, but the group's willingness to work together and cooperate are getting them done for less money. Although nothing really stopped them from working together like this

before, everyone was simply used to only working within their own facility. Establishment of the working groups has changed that mindset.

This same basic idea is being used for buying supplies in bulk. One group invited one of their common supply vendors to a meeting to discuss the possibility of the four facilities having consolidated purchasing power. One group member recalled how this happened and how popular he thought the idea would be:

(Another idea) is using the idea of combined buying power - buying in bulk, volume discounts for supplies. We have actually gotten one of our vendors to work with the hospitals as one customer instead of three or four. This is a really popular idea because it equates to real dollar savings that everyone can see.

They first had to check with their contracting office to ensure that no violation of the Competition in Contracting Act (CICA) would result. They were given a green light to have a meeting. Another group member was very relieved (and a little surprised) that there were no "stupid rules why they couldn't do it." He explains:

We're having a vendor come to one of our meetings to get their input on the ideas of volume buying for the four of us. I had to check to make sure that it didn't violate some type of contracting rules, but it's one of our current vendors, so we're OK.

Another group met with a different vendor to see if they could get a discount price from the vendor for a guaranteed volume.

The facilities wanted to set up one Blanket Purchase Agreement (BPA) for certain supplies they all used. A BPA is a contract for a specific dollar amount and is usually used for consumable, low priced or limited shelf life items. The contract is awarded once for an exact dollar amount, and items are ordered from the vendor throughout the fiscal year until all of the funds are exhausted. The benefits of this are many. If supplies are ordered frequently from the same vendor, a new contract does not need to be written for each order. Once the BPA is awarded, it eliminates administrative lead time and paperwork for each subsequent supply order. A benefit to the vendor is that they can count on a fairly certain dollar amount of business throughout the year from the customer with which they have the BPA. In the working group's case, the vendor they are working with is more than willing to lower prices in exchange for a combined BPA. The group is now sorting out the financial and paperwork details of the agreement with each facility's financial departments.

Although there are special financial and group contracting considerations with these issues that group member cannot complete themselves, they demonstrates that if given the opportunity, independent and traditionally non-related organizations can and will (or will find ways to) break traditional barriers to benefit from collective efforts and ideas. The working groups' mission to "coordinate sharing" is clearly demonstrated by these particular efforts.

c. Resource Utilization.

Working groups have come up with some innovative, very non-traditional ways to share their resources and increase efficiency. These include workload sharing, and eliminating duplications of effort. The idea of workload sharing is for each facility to share any excess capacity they may have with others who have overflows. This excess capacity can include testing, drawing blood, training, transportation, etc. It can be anything the facilities want and are willing to share. Duplication of effort involves different facilities purchasing the same equipment, doing the same work, etc.

Workload sharing is one way the labs are helping each other get more tests done within the military facilities. If more tests can be done within the MTF's, less money has to be spent sending the excess to civilian labs for processing. Sharing in this area has already begun among the facilities. Each hospital currently shares its testing facilities with the others. Although some hospitals are large while others are small with more limited resources, sharing between the military departments is done mostly on the basis of need and ability. The focus is on one service or good in exchange for another; the dollar amounts are not important. Interviews with working group members portray this cooperative spirit:

To save money we try to share services without actually having money changing hands. . . . With Hospital B and Hospital C, as long as we're helping out in some way, doing what we can, they consider that fair and equal payment.

Well, if I can do something for Hospital A and they can do something for me to help out, we don't care whose service costs more. To us it's an even trade.

I don't really send anything to Hospital B, but I'm not going to say they can't use (anything of ours) if I don't get anything from them. It is in my best interest to cooperate with them whether I get anything from them or not. Hospital A does a significant amount of lab tests for the rest of us because they are bigger. We just do what we can.

This workload sharing also goes beyond sharing the same kind of service (e.g., lab tests). If one facility has excess testing capacity and another has excess training capacity, those types of services are also being shared. This is done because the smaller hospitals do not have as many resources with which to share, so the groups are becoming creative. For example, two of the laboratories are relatively small compared to the third. If one facility doesn't have enough testing capacity to share, they are sharing other things. To balance the sharing scales, blood drives are now being conducted in exchange for lab tests. Another service that is shared is training for technicians in the hospitals. Two group members explained the sharing arrangements that have been discussed within their respective groups:

I see our group as a cooperative effort between the three services and the VA. It can be sharing resources, getting better prices on buying goods and

services that we all use and also in education. For example, Hospital A says they will be getting a lot more technicians and need places to train them. Well, their folks can train with us and if we need it our folks can train with them. We save money and get education and training we need.

Someone from Hospital A brought up the idea that since Hospital C doesn't have a really big lab to trade testing with, they can do something else. In return for one doing tests in the lab, the other has a really good training program for lab techs. Hospital C lets techs go through their training program in return for (having) lab tests (done). Again, no exchange of money, just goods for services.

There was no reason in the past why these types of arrangements could not be made. There were no legal, ethical or medical reasons why sharing of resources (personnel, materiel, material, etc.) could not have been done in the past. The only reasons that existed include parochialism, habit and the idea of "this is the way we've always done it." Use of the working groups to get personnel from the different services and the VA together to work out arrangements like these on their own has led to a more cooperative, coordinated, efficient way to provide healthcare to DOD and VA beneficiaries in the Tidewater area.

Duplication of effort and duplication of costs occur when two or more facilities provide the same service, conduct the same tests, and purchase the same equipment and supplies on different contracts. Efficiency can often be improved and costs lowered if one facility becomes the main provider of a particular service, or multiple contracts are

combined and awarded only once. This is precisely what the working groups are trying to accomplish. One idea that the Laboratory group thought of is to establish different hospitals as "primary test sites" for certain lab tests. One laboratory group member remembered how the idea came from one of the working group's first meetings:

With (four different hospitals) and all the clinics doing "X" type of tests, we probably don't all have to do all of the tests and duplicate efforts. What we talked about was all test "A" going one place and all test "B" getting done somewhere else.

Although this idea has not been implemented to date, the group is researching the possibilities of such an arrangement. This idea, however, would require the use of some type of transportation service to get all the tests to the primary test site. A transportation service was discussed earlier in this chapter and has been referred to the Project Office for implementation.

A few of the groups, especially the Shared Procurement group are looking at reducing or even eliminating duplicate procurement actions. One group is working with a vendor who has agreed to treat TRICARE as one customer and offer pricing based on total sales volume instead of individual hospital purchases. Group members have found it time consuming and frustrating figuring out for the first time how to have a contract prepared for an arrangement like this, but they feel once it is figured out, it will get easier with

each successive try. One group member explains both the frustration and hope:

We've managed to get one of our common vendors to treat the four of us like one agent. Now the whole issue is getting caught up in the finance offices. I guess it's because we're all not used to doing things like this. Money needs to be transferred here and there, and now the VA's involved and we all do things differently. But once it gets worked out and it's done once, it will get easier and easier the next time and the next. Once we start a new habit of doing contracts this way, it will seem more normal.

This group member understands that there may be some obstacles that need to be hurdled to change the way they traditionally do business. He also understands that once these problems are tackled, the evolution becomes easier as new ways to do business emerge. Consolidation and cooperation can then become the norm and instead of the exception.

Another group has also gotten a current vendor to offer substantially better discounts based on a common BPA contract that includes all services and the VA. Funding information will come from each individual agency, but duplicate procurement contracts will be eliminated. This not only reduces paperwork and total contract preparation time, it also reduces cost because better discounts are being offered by vendors based on a larger volume of sales.

4. Horizontal Communication.

Use of the working groups has resulted in an increase in lateral or horizontal communication among the different

agencies. In the past, each hospital was an independent facility. People in each hospital/clinic had little dealings with those in a different service. Navy hospital and Navy clinic personnel talked to each other because they were in the same service, but Navy hospital and Army hospital personnel, for example, did not. Several individuals expressed this traditional mindset during interviews. When asked if they ever worked with anyone in their group from the other facilities before, most individuals said no. Responses like "no, I never had any reason to," or "no, before everyone just did their own thing" were common. Now that individuals have been working together in the working groups, they communicate with each other much more often.

When asked what communication was like before TRICARE and how it has changed as a result of their participation in the working groups, some group members said:

Before this, the Navy was here, the Army was here, the Air Force was here and everyone lived in their own little world. This has opened up the lines of communication because everyone knows each other now and feels free to call each other. Before then, I didn't even know the people at the other hospitals and they didn't know me. It's not that I wouldn't call anyone, but if you know people you're more likely to call. Just from working together, we can call each other now for advice, help.

Before this I never contacted the VA for anything. Now we have meetings once a month plus I talk to them at least one other time. I talk to (the other hospitals) a lot more now because we're working together.

In addition, group members were asked to recall a time when they did call their colleagues in other services or facilities for help or advice. Some of the respondents recalled the following:

I remember once I was reading a newsletter or a journal or something and I was looking at a new piece of equipment that (a vendor) was marketing. I didn't know much about the vendor, so I called (my colleague) from (one of the other hospitals) and asked if he knew anything about this company or the machine. I don't think he knew much more than I did, but the point is, I wouldn't have even called him before. Now that we've worked together I don't feel reluctant to call.

I've called other group members to talk about an issue we're working on in the group and ended up asking them a professional question about procedures or tests or else answering the same kind of question about a conversation. I remember once I was talking to someone and we started talking about stuff we had heard at a conference a while back. I've made more professional contacts being in the group. I'm more likely to call any of them now since I know them. Most people won't call a stranger to ask them a question or advice. We're not strangers anymore.

Calling colleagues to ask professional advice or get information on new medical procedures, equipment or standards is nothing new. What is new is the network of colleagues that is being developed in the Tidewater area as a result of individual participation in TRICARE's FWG's. The communication links that have developed have crossed not only departmental lines, but hospital and service lines as well. This new horizontal dimension is a vital aspect of TRICARE's success. The goals of coordinating the delivery of healthcare among the Army, Navy, Air Force and the VA cannot be achieved

without establishing horizontal communication links. In this area, the FWG's have been very successful.

5. Sharing Arrangements Between DOD and VA

The VA and DOD have been coordinating their efforts in an attempt to provide better service to DOD and VA beneficiaries. Of great initial concern to both TRICARE and the VA was the possible existence of legal reasons why they could not meet together, share resources and combine contracting actions. On 26 May 1993, one TRICARE administrator held a telephone conversation with Mr. John Casciotti, General Counsel for ASD(HA) to discuss resource sharing between the DOD and the VA. Mr. Casciotti stated unequivocally that no legal or contractual impediments to increased communications, resource sharing or involvement in TRICARE meetings exists. Therefore, the sharing of material, resources and support services are both legal and non-controversial. The only obstacles that did exist were the traditional roles each had in providing healthcare. It is the opinion of many group members interviewed that shared procurement issues are no more difficult with the addition of the VA. What has been difficult for the groups is sharing goods and services with no actual monetary reimbursement.

Group members are becoming innovative in coming up with ideas to allow DOD and the VA to easily work together to share resources. One way they are promoting sharing is they

are writing sharing agreements or Memorandums of Understanding (MOU's). As mentioned earlier in this chapter, the military services and the VA want to be able to share equally needed resources without the actual exchange of money. Transferring money from one service to another was viewed by one group member as being next to impossible. He said:

We have had a problem, not really a big problem I guess, making sure that we didn't have to exchange any money. I don't know if you know, but it's almost impossible for two government agencies to give money to each other. I had no idea what the rules were. Swapping money between DOD agencies is just too hard. We can swap money with the VA, but we didn't want to. We wanted to set up some arrangement so we don't have to exchange money.

The group members wanted to avoid the pain of having to prepare paperwork needed to reimburse another facility for services provided. This not only delays the process, but it also creates more work for someone else. They wanted this process to be as simple and painless as possible. The military services each agreed that they would share what they could share best and the value of the good or service would not be an issue. The VA, on the other hand, is under different budget controls and is quite concerned about the dollar value of services they provide compared to services they receive. To accommodate this difference in viewpoints, the military services are developing sharing agreements or MOU's with the VA. These MOU's allow the exchange of equal values of goods and services. Since this involved exchanging

individual goods and services for specific dollar amounts, the MOU is considered a contract. One group member explained why sharing agreements were being written:

We are currently writing sharing agreements between each service and the VA to be able to share the labs. It's like a contract because the VA is trying to match (the sharing) dollar for dollar instead of service for service. . . . (W)e (the military) don't care whose service costs more. The VA wants each service to be worth the same money. I think it's because their budget constraints are tighter than ours.

Unfortunately, the necessity to prepare a contract makes putting this idea into practice more complicated and take longer than simply shaking hands. Regardless of this delay, group members remain confident that once all of the paperwork has been sorted out, sharing among everyone will be greatly enhanced. To help speed the process along, one of the members from the VA brought a contracting representative to one of his group's meetings. Instead of taking questions back to the VA and the group having to wait for a response, the contracting representative was at the meeting readily available to ask and answer any questions related to the arrangement. It was decided that certain services would be specifically listed in the MOU with their associated dollar value. This document could be used to ensure that if an HIV test was done at the VA for one of the military hospitals, then equally valued goods or services would be received in return. Once this document is prepared, the VA will have an easy reference for and an

easier time sharing their collective resources with the DOD facilities.

This section has provided evidence that use of working groups can have positive effects on the implementation of change in an organization. TRICARE's working groups have made many advances in changing the healthcare environment in the Tidewater area from a single service to a multi-agency effort. Unfortunately, with good there also comes bad. The next section will detail what obstacles still need to be cleared to allow TRICARE working groups to be more effective agents for change.

C. FWG's - WHAT'S NOT WORKING

During the course of this research, several issues surfaces that have caused the working groups to have difficulty achieving their goals. These issues are:

1. Team members are getting frustrated because resolution of their issues is being delayed because of action required from others.
2. High turnover rate of military group members has impaired group progress and effectiveness.
3. Perceived lack of organizational importance of working group efforts and issues has impaired group member enthusiasm.
4. The Managed Care/Coordinated Care Program is being viewed by some group members as simply another DOD program that, if given time, will be cancelled and replaced by something else.

These issues were conveyed during interviews by a majority of group members and will be addressed in this section one at a time.

1. External Integration.

As outlined in Chapter IV, there are several factors that can promote or hinder group success. One of these is the degree to which a group depends on the actions of those outside their group. The higher the degree of required external integration, the more group effectiveness depends on the pace, productivity and workload of others. If the pace of outsiders is good, group effectiveness can be positively influenced. But if it is poor, a group's progress and reputation can suffer through no fault of their own. Several groups are currently waiting for action from people or departments outside their group for implementation/resolution of some of their issues and proposals. Groups are not only waiting for others to act, they are getting frustrated because they think the resolution/implementation process is taking too long. Three examples of frustration caused by outside integration surfaced during interviews. These examples involve the contracting of a transportation service, the preparing of shared procurement contracts and the writing of sharing agreements between the military services and the VA.

a. *Transportation Service.*

The first example is the transportation issue discussed in the previous section. The transportation service is viewed by most all groups as an important element upon which sharing of most of their services and resources depends. For example, the pharmacies want to share short dated drugs, the laboratories want to share testing facilities, and contracts and other paperwork could be transported for the Information Systems, Shared Procurement and Staff Development groups. Implementation of this proposal has been taken out of the hands of the groups and taken by the Project Office for action. One group had researched the idea, contacted vendors for price quotes and made a proposal to the Commanders' Board. The Commanders' Board enthusiastically approved the idea and turned it over to the Project Office for further action. Once this happened, group members lost ownership of the idea and also lost track of its progress. One group member was asked if he knew the current status of the courier service proposal. He said:

The Commander's Board liked the idea and from there it has gotten delayed because, because, I'm not really sure why. Surveys were sent out, but to the wrong people.

When the idea was initially proposed and accepted, group members were very excited at the prospect of having one of their ideas implemented. They were seeing positive results of their efforts and felt like they were actually making a

difference. As time went on, however, enthusiasm dwindled as the issue seemed to get lost in the system. This group member has become disheartened with the handling of the proposal. He went on to say:

If there's one thing that I could say negative against this whole procedure is that not everyone has the same urgency to get things done. This courier service that we all really need has taken forever.

Someone (group members did not know who) was tasked to prepare and distribute a survey to determine what other departments would be interested in using a courier service if one was available. This is the point where group members began feeling frustrated. They felt that resolution/implementation of the transportation service was taking too long. Part of this frustration was due to lack of information. Group members did not seem to know the status of the issue and were very uncomfortable with their lack of knowledge. Group members did not resent the fact that tasking for completion of the project was given to someone else, they were unhappy because they did not know where the project stood. They were also unhappy that resolution depended on the action of someone else and they didn't know what the other person or department's priorities were. Another individual described the courier service issue as "winning the prize for getting lost in the bureaucracy the longest." When asked what his group's biggest obstacle was, he responded with:

I guess that would be when a decision requires a commitment of resources out of our control. We all work well together doing what we can (among ourselves) and we're pretty successful when we don't have to go outside the group. **But when we have to go outside of the group for a decision or for resources, that's when things get bogged down.** Like the courier service. We think there's big savings to be realized if we can get a service going. We don't have the authority to commit the resources and no one seems to be able to come up with the ability to do it.

Administrators wanted to make sure that if a courier service was used, the most benefit would be received by everyone in the organization who was interested. This is why a survey was being distributed. One group member expressed his frustration with the survey process:

Someone else was tasked to do the survey by the Commanders' Board. I don't even know who. They wanted to know who would be interested in using such a service, so they sent out a survey. They didn't get a good response so they had to send out another one. I never even saw the first survey. . . . I know they're working on it, but what's taking so long is beyond me.

Q. When you say "they" are working on it, who is "they?"

I have no idea.

When asked if he was disappointed that someone else was doing the survey, this individual said no. He was disappointed, however, that things were not turning around as quickly as he had hoped or thought they should. Still another individual in another group expressed frustration, but no great surprise, that things were taking so long. He even seemed to expect it. During his interview he said:

. . . all that slows it down because now they're doing a survey to see who needs the service and how much they need it. It's slow but I don't think it's any slower than you expect. . . . I just think that it takes time to see results because of the big organization that I mentioned earlier.

This individual sees slow resolution of any issue within the military as the norm. He feels that the transportation service is an important issue for TRICARE and the sharing effort and would like to see it implemented as soon as possible. He does, however, expect delays and is not surprised by them. Another group member, who also feels that the transportation service issue is a key element in their collective sharing, thinks that it has been "a lot of work with no results." Group members also don't feel that they are being kept informed as to the status of the project. One member said "We don't even know what's going on anymore!"

b. Shared Procurement Contracts.

A second example of frustration caused by outside integration is the shared procurement contracts that are being prepared. Many of the groups are looking to get better prices from vendors by combining their buying power. The groups talk to the vendors, collect information regarding terms and pricing. Once they find a willing vendor, they have to send their ideas to the contract and/or finance offices for review, paperwork preparation and/or approval. This involvement of outside parties has caused considerable distress among group members. They have no objection to the contracting office

doing the contracting or the finance office doing the financing. What concerns them is the amount of time it is taking to get anything done. One group in particular is looking at combining contracts for providing oxygen for the home oxygen programs at the hospitals. The group has worked out the details with the vendor and is now waiting for financing issues to be resolved. One group member expressed concern with the length of the process:

We've been working among ourselves to get everything agreed upon. Now we're just waiting for the finance offices to get things done. It's like a hurry up and wait. We work hard to get proposals in the works and then it seems like we wait for everyone else to get around to it so we can finish.

It's not that group members do not want anyone outside their group involved in decision making. They do not like being "kept in the dark" on where their projects stand. The biggest frustration seems to be in the lack of information on the status of projects once they leave the group's internal control. Once issues are forwarded to other departments for action, group members don't think that fast enough turnaround is received or that they know what is causing delays. One group member stated that

I know everyone's very busy and has a lot of work to do, but we'd like to know where it stands. I know this (home oxygen) issue is hung up with the finance people, but why I don't know. I can't imagine what can be taking so long.

This individual, as well as other group members, don't think for a minute that they can prepare contracts or that they know enough about financing procedures to do everything themselves. They do, however, question the time it has taken to resolve many of their issues. When possible, group members invite contracting or other personnel to their meetings to answer questions about the possibility or legality of some of their ideas. This provides immediate feedback when other parties outside the group are readily available at meetings. But when it comes to the actual preparing of paperwork (contracts, funds transfers, etc.) group members have to turn over control to someone else. It is the time it takes and reason for delays that is the issue, not the specific involvement of external parties.

c. Sharing Agreements.

Still another example of when groups have gotten impatient waiting on the actions of others outside their group is the sharing agreements (MOU's) that are being written between the services and the VA. These sharing agreements are being prepared to allow the different hospitals and clinics to share laboratory facilities. Group members wanted to prepare a single sharing agreement to include all military facilities and the VA. Since the exact dollar value of services are specified in the agreement, the documents are being reviewed and approved by contracting personnel in the respective facilities. Group members found the idea of combining all

agreements into one to be a "contractual nightmare" and decided it would be easier for each facility to prepare their own MOU and list the equipment and services they wanted to share along with their respective prices. Each service was then responsible for coordinating their own MOU with the VA. One group member recalls the confusion that has been occurring during the preparation process as documents go from the VA contracts office to the military contracts office:

We tried to set up one blanket agreement with everyone but it didn't work. (It was too complicated.) We had to do three separate agreements with Langley and the VA, Portsmouth and the VA and Ft. Eustis and the VA. It goes to the contracts people over here, and they didn't like the wording, so they sent it back (to the VA) and now they have it back here again. The VA specified prices for tests in the agreement, which is OK except they had other tests in there except for the lab tests (and the contracts people didn't like that).

This individual thought that the contracting people were being unnecessarily picky, but he also didn't know what exactly was involved in preparing a contract. He was speaking not from experience with contracts but from his perception of how things should work. Another group member finds the waiting game "irritating." He also feels that the group's progress and efficiency are being hampered because of having to wait for other people to act. During his interview, he explained his concern:

I guess it's just irritating not knowing what's going on. We've been told to work together and see how we can work together. We've figured some things out, but

we can't do it because we don't have a piece of paper signed saying we can. The MOU's we're waiting on and the transportation business. It's taking forever. When you get too many hands in the pot nothing gets done. They're all good ideas, but sometimes I wonder if it's not just too much trouble - too much red tape involved.

This individual feels frustrated that they were given a mission to see how they can work together and share resources. He feels that they have come up with some good ideas to allow that to happen but can't implement them because there is too much paperwork and too many other people involved. This is the "red tape" he is talking about - paperwork, contracting actions, and figuring out how joint payment is going to be made to name a few. He feels that his group has come up with good ideas to promote sharing but that they have been provided with no means to easily implement them. No one in the group is knowledgeable in the area of contracting or finance, so resolution of their issues must be put on hold while they are sent to one of these departments for review.

When looking at the amount of external integration required by the working groups, most group members gave the impression that if the response they received from outside the group was faster or if they had been kept more informed on the status of actions, they wouldn't have felt so frustrated. Data collected during this research suggests that the departments of contracting and finance are the ones with which group members integrate and require additional action from the

most. If special ties and unique working relationships could be developed between the FWG's and these two departments, resolution of working group issues could be done with less pain and frustration. From the external perspective, the contracting and finance departments have other things to do besides resolve working group issues. Other bills still must be paid and other contracts still processed. Special attention must also be paid to the additional workload created in these departments as a result of working group business. For example, because one group thought that coordinating four contracting offices would be too difficult, each service is preparing their own sharing agreement with the VA. This equates to some duplication of effort in the contracting offices in order to eliminate duplication of effort in the laboratories. What is saving time and money in one area is creating more work in another.

2. High Turnover.

Much of a group's success depends on how well group members work together and get along. When a member first joins an established group, one can expect that it takes a little time for the individual to "catch up" with what the group has been working on, getting to know other group members, understanding group norms, and learning how they work together. With this in mind, if group membership changes often, any wisdom gained from experience and the contributions

of departing members, unless fully understood by new members, can be lost forever. New members will need to be briefed on what the group is currently doing, what they have done and what they plan to do. This initiation process of new members can certainly slow the progress of groups like these that meet, at most, once a month.

One group member feels that his group has had a difficult time getting things done because turnover in the group has been exceptionally high. Frequent changes in this group's membership have, in his opinion, been due to a high percentage of military members. In contrast, members of some of the other groups feel that one reason their groups have been successful is because they have had virtually the same group membership from the beginning. One particular group member felt that this particular point has contributed to the cohesiveness of his group since the same people can be counted on all the time. Group members all know each other, have learned to understand and trust each other and have become accustomed to the habits and personalities of other group members. They are all knowledgeable on current and pending issues, and new members don't need to be "trained" very often. He explains the positive results of having the same members:

We've had the same committee for one year and no one has asked to be replaced by someone else. Everyone is very active and very excited.

He feels that having the same membership for a year has been a contributing factor to his group's effectiveness.

Military members of a working group present a unique problem to group stability. While they may be the biggest contributors in a group, they are subject to frequent transfer. While civilians also transfer and are at times replaced by new members, they are not subject to transfer as frequently as military members. By the time a new military staff member reports to the command, becomes familiar with their job, familiar with the organization and familiar with the issues of the working group, a good percentage of their tour is over. Since it would not be practical to assign someone to a working group who is neither familiar with their job nor the organization in which they work, military members are not normally assigned to working groups immediately upon arrival. If military members don't get assigned to a group early in their tour, time becomes even more of a limiting factor.

If a group has a low percentage of military members, productivity would only infrequently be interrupted when one of these members transfers. However, if a group has a very high percentage of military members, group progress would be interrupted extremely often as each member comes and goes at different times. This is a unique problem that one of the groups is facing. One member of this particular group feels very frustrated because his group has a hard time getting

things done. He blames this in part on frequent membership changes. He explains his frustration:

We've been meeting for about two years and it seems like every few months someone's been replaced. It's not that people aren't enthusiastic or quit, in fact everyone comes to the group with real energy. The problem is military people transfer or they go to another job and someone else takes over for them at work and in the group. Each person contributes, but when you have someone new, you have to stop with each issue and catch them up. It really becomes a problem when you want to get anything done. Turnover is a really big problem.

This individual has been a dedicated group member for the duration and feels that if he could add a bit of membership stability to his group, they could accomplish more and be more productive.

As brainstorming takes place within the group, ideas are discussed and prioritized, and some ideas are chosen to act upon. This group has worked well together and initial problems with individual participation were quickly resolved. Members that have been assigned to the group have been enthusiastic and productive. Problems have occurred when members transfer and need to be replaced. This results in several detractors from group progress and effectiveness. First, new members need to be indoctrinated to group procedures, norms, expectations and briefed on current and planned action items. This takes time away from the group's productive activities. Secondly, any working relationships that have been developed with vendors or individuals in other

groups or departments become severed when that member transfers from the group. Action items that they have been researching have to be reassigned and new working relationships established. This effect of group membership is not unique to TRICARE's FWG's. Any group with a high rate of turnover would experience the same problems. What is unique in this case is the reason for the high turnover - military members. If the percentage of military members could be kept to a minimum or a required membership time (e.g. two year minimum membership) established, the negative effects could be minimized.

3. Perceived Lack of Organizational Support.

While some individuals are motivated by status, money and fame, others are motivated by recognition of a job well done, personal pride or a simple "thank you." The working groups work hard and want to be recognized for their efforts. They want the organization to recognize issues they consider to be important in carrying out the mission they were given by the TRICARE Commanders' Board. Many group members feel that since issues are taking so long to be resolved, they are not getting the organizational support they need to accomplish their mission. Group members not only feel that the organization does not support their efforts enough, they presented no evidence of any type of reward or recognition system for the working groups or its members. One of

Hackman's enabling conditions that impacts group effectiveness is organizational support and reinforcement (including reward and educational systems). Effective groups require organizational support. According to Hackman, in order for groups to achieve maximum effectiveness, groups (not individuals) should be provided with reward systems such as performance incentives, educational systems such as professional and interpersonal team training and expert coaching and process assistance to maximize effort, commitment, knowledge and skills.

No specific group reward systems are currently in place that provide FWG's or their members with the incentive to perform well. Members rely on their own feelings of satisfaction and achievement to intrinsically motivate themselves. Since no external rewards exist, groups members must also encourage each other. When they see the positive products of their own labor (cost savings, increased efficiency), they collectively feel good about the fact that they can really make a difference. If no immediate measures of success are readily apparent, group members have a difficult time seeing the benefits of their efforts without some other type of incentive.

TRICARE also has no formal education and training system in place for the groups. Even though TRICARE doesn't have formal training available, one hospital has an active training schedule which has shown positive results. It is

available to anyone in the facility who is interested. The training that is offered helps people develop interpersonal skills and understand how groups function. This particular hospital has many working groups within the facility that deal with hospital specific issues. The training is available to individuals because that particular base commander endorses and encourages it. It is not specifically in support of TRICARE's FWG's. One individual from that hospital who has been through the training thinks it was extremely educational and helpful to their working group involvement. They explained how training was provided:

The commander wants as many people as possible on the base to get to go to training. You go when you have the time and as many people go as possible. In the command here it is very positive for people to go to training because the commander endorses it. He even encourages it. I think it really helped me work on the group. I felt more comfortable and confident about what working in a group would be like. They also have a week long advanced course if you want to go.

In this hospital, training was not only available, it was encouraged. It wasn't mandatory for anyone, but the perceived support from the hospital commander gave people the incentive to go. The commander's support of the training also gave supervisors more leniency in allowing people time off from their regular duties to go to training. This element of Hackman's enabling conditions is missing in the TRICARE organization. Although there was no specific evidence

uncovered during this research that people who did not go to training have done poorly in the groups, those who were provided with training saw it as a positive influence on the quality of their participation.

Group members also do not think that the organization places enough emphasis on the quick resolution of issues that working groups see as important. One group member explained what he thought the problem was:

If there's one thing that I could say negative against this whole procedure is that not everyone has the same urgency to get things done. The courier service, that we all really need has taken forever, and the MOU has taken longer than it should.

Issues such as the courier service and the writing of sharing agreements seem (to working group members) to pass through the organization with as little priority as routine business. This may in fact not be true, but this is the perception of working group members. Frustration is being caused, in part, by the lack of information group members have on the status of their projects. When group members don't know what is being done with an issue, they assume that nothing is being done. While this may far from the truth, hard feelings are often based on perception rather than fact. Subsection one of this section (*External Integration*) details all of the issues that working group members feel are not getting timely consideration. The detailed examples are the same in the two sections and don't need repeated. The issues involved, however, are quite

different. While the *External Integration* subsection deals with interaction with individuals outside the department, this issue deals mainly with perceptions of support (or lack of support) from the TRICARE administration (Project Office, Commanders' Board, etc.) For example, as one group was working on the transportation issue, they felt like they were making progress and doing a good job - making a difference. Once the issue was recommended to the TRICARE Commanders' Board, it was turned over to the Project Office for further action and implementation. From that point, group members stopped seeing steady progress toward actual implementation. The reasons why actions take so long are unknown to group members and may be very valid reasons from an organizational perspective. Since group members don't know the reason, they view it as or assume that it is because of lack of interest and support of management. This perception has detracted from group member enthusiasm.

Another action, or lack of action, that has contributed to this perception is the chartering of groups and formal appointing of group members. Some groups had been meeting for over a year before the organization formally recognized them with official appointment letters for group members along with a written charter for the group. While group members were meeting to support the tri-service effort, they were not officially recognized by the organization. Prior to its members receiving appointment letters, one group

was having difficulty getting one of its members to attend meetings on a regular basis. When he was asked why his participation was so limited, he stated that he worked for the hospital commander, not for the TRICARE office. Not long after, this individual received an appointment letter, signed and sanctioned by the hospital commander, and his perspective quickly changed. Once he felt that the group's efforts were important to his ultimate superior, he was more willing to participate. The official charter and appointment letters also gave group members more of a feeling that the organization not only recognized their participation but that it also endorsed and supported it.

4. Another DOD Program.

Over the past several decades, the DOD has implemented many programs that after a few years were replaced by others. Some group members find it hard to dedicate a lot of their time to a program that they fear will become another one of DOD's "fly by night" programs. A few of the group members interviewed felt a great sense of responsibility to their regular "9-5" job and dedicated their time to working group efforts only when they "had the time." One group member relayed his dilemma:

It's hard to have faith in any of the military's programs. They change every time the administration changes. I think a lot of things we do are good ideas, but people are reluctant to put a lot of effort into this if they think it's just going to be

abandoned later. TRICARE, as far as I know, is just a test project. If (someone above us) doesn't like it, then we're just going to go back to the old way anyway. When Clinton goes, maybe the next guy won't care about healthcare as much.

Many people have seen Army, Navy and Air Force programs come and go and remember all of the (what they feel was) wasted time they spend. They are not being given a good feeling of permanence of the program. Group members need to be given a reason to believe that this program is not going to just go away like many other programs they have seen.

Another group member, when asked why he thought some people were reluctant to enthusiastically participate in the groups and why some people didn't even come to the meetings. He said:

The basic problem is that people's concern is not what's going on at another facility. Their job is to do their job and often it doesn't extend beyond that. All they see is the line outside their door, the stack of paperwork on their desk. They've got a lot of work to do.

Group members, and probably many other hospital employees don't have a good macro view of the Coordinated Care Program or of TRICARE itself. They don't see the benefits of the program because they don't understand all of the aspects of the program. They see and understand how TRICARE affects their immediate work area, but they don't fully appreciate the overall goals of TRICARE (improve access, maintain quality and contain costs). After further reflection, this individual

expressed possible concerns that military people have about their fitness reports or annual evaluations.

A lot of civilians work in the same place for a long time, so they probably will tend to have more of a long term commitment to (projects). They can get evaluated on the outcome of a project they have been working on for a long time. Military people are only evaluated on what they do while they're stationed at their job. They don't get evaluated on long term things because when you finally see results, they're gone. I would tend to say that military folks are more concerned about what is going on now. They have to be more concerned with their regular job because that's what the boss sees and that's what goes on their fitness report. Their fitness report may say "participated in a working group for TRICARE" but that probably doesn't count for a whole lot for promotion.

This individual's point was not that military members of groups don't contribute or that they're not needed. His point is that he feels that military people have a difficult time dividing their time between what is going on right now and activities that may make life easier one, five or ten years from now. They are not around for the long term, so their view is not typically based on long term either. This is a legitimate concern for military members of the working groups. In the opinion of this researcher, if there are no rewards within the military evaluation system for outstanding participation in programs like TRICARE and the FWG's, most military individuals have little incentive to take time away from those activities that directly influence fitness report scores. TRICARE is not providing these individuals any additional rewards or incentives for their participation.

Their fitness reports will, most certainly, contain a bullet that states that they were "an active, integral member of one of TRICARE's working groups," but most individuals won't view this as being very critical to promotion potential. If no rewards are available within the military system, the TRICARE organization must provide some.

D. Summary.

All of the issues discussed in this chapter, both good and bad, were gleaned from interviews with working group members and Project Office personnel. Situations discussed in this paper are explained based on group members' perceptions of events that have occurred and the effect these events had on their respective groups. Stories were told by group members during interviews and were based on their best recollection and understanding of what happened and why. Differences between what was intended by the administration and what was perceived by working group members can be used by TRICARE as a learning tool for future actions, directives and training activities involving working groups.

VI. CONCLUSIONS AND RECOMMENDATIONS

Chapter V identified "what's working" and "what's not working" with TRICARE's Federal Working Groups. Many of the issues showed that use of interservice working groups can enhance the cooperative effort while others showed that there are still some stumbling blocks that still need to be overcome. Several conclusions were made as a result of the research.

Conclusion #1. TRICARE's use of Federal Working Groups is an excellent way to foster interservice cooperation among the services and the VA. TRICARE's approach of participative management requires a vehicle for workers to provide input into the change process. FWG's have effectively been used to get workers from similar departments to get together and decide what changes need to be made at the working level. If participation is the goal, then participation must be allowed and encouraged.

Recommendation: TRICARE should continue to use working groups to facilitate interservice communication and aid in the change process. Present groups should continue to meet and additional groups should be formed as needs arise. Groups should not be formed simply for the sake of having more groups. They should only be formed if administrators (based

on worker input) feel that one is needed to assist facility employees in accepting and promoting change.

Conclusion #2: Current working group size and member mix is consistent with enhancing group effectiveness. According to O'Reilley and Roberts (1977), the size and mix of the group affect group effectiveness. Groups should be small enough to facilitate interaction among its members but contain a sufficient number of members to ensure all interested parties are represented. In the case of TRICARE, working groups are small with each hospital and, in some cases, clinics represented. Groups should also contain a good mix of individuals who are neither so similar to one another that they are like peas in a pod nor so different that they have trouble working together. Federal Working Group members all come from similar departments in each medical facility with similar job descriptions. The only dissimilarity that could potentially hinder group effectiveness is the inherent difference between the military medical function and that of the VA.

Recommendation: TRICARE should continue to ensure that all parties within the organization are represented on working groups. Consideration should be given to changing the group mix by placing representatives from the contracting and/or finance departments on the groups. If these individuals became involved in group decision making, they could answer questions about contractual and financial limitations that may

be involved in implementation of some of their ideas. This would eliminate progress delays that require one or more group members to go back and consult with their respective contract/finance offices. It would also ensure that suggestions that would save time and money for departments involved in working groups would not result in more work and costs in these other departments.

Conclusion #3. Because of the high degree of external integration required by the working groups, group progress has been slowed and individual motivation has suffered. The more the groups have had to depend on the actions of others (surveys for courier service, contracting issues for MOU's, etc.), the more group effectiveness depends on the pace, productivity and workload of others. In TRICARE's case, group projects are being put on hold while research or other action is being done by someone outside the group. Evidence suggests that groups tend to externally integrate with the contracting and/or finance departments the most. Group progress tended to stop when external assistance was required when contracting issues arose or providing collective funds was needed. The home oxygen issue was delayed by funding issues, the transportation issue and the MOU's stopped as soon as contracting concerns became an issue. As within most organizations, priorities within departments exist and the most urgent items are done first and then each successively less urgent item. Working group members don't know where their items sit on the

priority scale within the organization or within other departments.

Recommendation. If the new Coordinated Care effort is to be perceived by workers as an important, command-supported endeavor, then actions that result from working group efforts must be given high priority within the organization. If not, group members will see little significance to their proposals and not worth the effort they expend. Groups must be given frequent feedback as to the exact status of their action items. Simply telling them that "a survey is being conducted" is not sufficient. Group members want to know what is being done, who's doing it and when they can expect proposals to be implemented. Each action item is very important to each group member (if not they wouldn't waste time discussing them). If action is required outside the group, those actions need to be given a sense of priority and feedback must be given to the group as to the status of the action. Meetings between group leaders and Project Office personnel are an excellent way to keep group leaders informed of action status. Group leaders can discuss any of their groups' concerns and then relay information back to their group at their next meeting.

Integral relationships must also be developed between the working groups and the contracting and finance departments. This can be done one of several ways. Membership of existing groups could be augmented with members from one or both of these departments. This would ensure that

contracting and finance concerns and requirements would be considered in group recommendations. It would also give existing working groups an available resource to refer to during meetings. A new working group from contracting and finance could also be formed to act on pending TRICARE issues. They could meet as necessary and would ensure that what is saving time and money in one area is not creating an additional administrative, contractual or financial burden in another.

Conclusion #4: Groups were formed with the goal of increasing lateral communication and sharing among the medical facilities. They were not however given enough initial direction or guidance. One of Hackman's "trip wires" was that management assembles a large group of people, tells them what is to be accomplished with only general details and lets them work out the details. Many of the groups had been meeting for over a year before they were officially chartered and group members received appointment letters. This may not be a problem if group members happen to have the same goals as management, but this is not always the case. Some of TRICARE's groups were initially successful, but even those groups were, at first, unclear as to how much latitude they had and how much permission they needed to get before certain actions could be taken. Other groups had members who did not see much organizational importance in being on a group that wasn't officially chartered by the organization. Once

appointment letters were distributed and charters prepared, it all seemed more worth the effort.

Recommendation: Appointment letters should be given to members prior to their first meeting or at their first meeting. Groups should be given official tasking by the Commanders' Board as soon as possible. If possible, group members should be invited to a Commanders' Board meeting prior to their first meeting. The Commanders could express their support for the group and advise them as to what types of decisions and changes they can make on their own and what types will require approval and from whom. Group members need to be perfectly clear as to their mission, goals and how much latitude they have for making decisions on their own. They also need to have a good feeling that the organization supports their efforts and sees their participation as important and necessary to the success of the organization.

Conclusion #5: Group members have not received enough training or coaching to prepare them to work as effective groups. According to Hackman, some organizational factors that aid group effectiveness are the availability of professional training and expert coaching and process assistance. TRICARE provides groups the means and the opportunity to work together. Group members are not provided with training or with a facilitator to provide the group with coaching and assistance. If the groups "hits it off" right away like some of the FWG's did, then giving them the

opportunity to work together may be a sufficient catalyst to promote consolidation, cooperation and changing of old habits. If groups have less instant success, they may need assistance from a facilitator. Otherwise, groups may flounder and make little progress for a long period of time. If groups are left alone when having difficulty getting started, they may become so frustrated that they give up and become completely unproductive.

Recommendation: When groups first start meeting, a trained facilitator should be one of the initial members. The facilitator should be trained in leading a group and must also be extremely knowledgeable about the overall TRICARE organization, its mission and goals. The facilitator must have a direct line of communication with decision makers to provide timely feedback to groups when questions arise. Group members should also be offered training prior to their involvement on working groups. One of Hackman's "trip wires" is that group designers assume members already have all of the competence necessary to work well as a team. Average individuals in a military organization may not have the interpersonal skills or knowledge necessary to work well in a multi-service working groups. Although no explicit evidence exists that working group members who have not received training are less effective than those who have, it is also wrong to assume that everyone has all of the necessary competencies. It has also been shown in this research that

those individuals who have received training viewed it as positive motivation and preparation for their working group involvement.

Conclusion #6. Working group members felt more satisfaction when they could see evidence of progress and feel that they were actually making a difference. Evidence that they were making a difference includes seeing increases in efficiency and reduced costs within their department(s). This can include less waste, lower costs or quicker turnaround on departmental jobs. One example of this was when one group member expressed that his boss was happy about his involvement in the group because they could see a measurable decrease in the number of lab samples that had to be sent out for testing. He could see a real cost savings as a result of his working group's efforts and so could his boss. Another example is the sharing of short dated drugs by the pharmacies. This not only equated to less waste, but also \$100,000 in cost savings in one year's time. When group members can actually see how their efforts are making a measurable difference, they are more proud of their and their group's efforts. This attitude keeps motivation and levels of participation high.

Recommendation. If groups can readily see how their efforts are making a difference throughout the organization, little action is required on the part of administrators to give groups a feeling of accomplishment. The working groups should be recognized for their achievements and encouraged to

continue with outstanding performance. If effects of group performance are not easily seen by group members, groups must still be recognized for their efforts and shown how their contributions are making a difference in the organization, no matter how small. If group members can see that progress is being made toward their end goal and feel that their efforts are noticed and appreciated by superiors, they will continue to strive for success. If group members feel like their efforts are not appreciated or that they are working to no end, then their motivation and enthusiasm will dwindle until they are no longer a productive member of the group.

Conclusion #7. Groups that worked on more independent, autonomous tasks felt a greater sense of achievement than those that required outside assistance. For example, the laboratory working group proposed the use of a courier service to transport materials from one hospital to another. They, as well as other groups, felt that this was a critical element to allow sharing between the hospitals. This proposal required a survey and a contract. These actions were given to others to resolve. In the meantime, the group independently developed their own transportation service to use while paperwork for the "official" one was being completed. This autonomous act gave group members a sense of accomplishment. While this ad-hoc service is only meant to be temporary, it has provided the group with an effective way to help themselves. The pharmacy group started sharing short dated

drugs with each other as soon as they decided to do so. It was easy to implement because they didn't need anyone else's help, they just let each other know what was available and where it could be found. Each group was doing something for themselves to allow sharing to take place without needing anyone else's help or approval. When things are easy to do, they are more likely to be done.

Recommendation. Groups should be given as much autonomy and decision making authority as possible. Like the lab and pharmacy groups, other groups will feel a real sense of accomplishment when they can do something to help themselves without having to ask permission or get assistance from others. Groups should be specifically told from the start just how much autonomy they have. They should know what actions they can take on their own and what types of decisions should be referred to higher authority. The less permission that has to be asked, the more likely groups will be to act.

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